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EDITORIALS†

SIXTY-NINTH ANNUAL SESSION: CORONADO, MAY 6-9

Annual Session Proceedings Will Appear in June Issue.—Much of the preliminary story of this year's annual session of the California Medical Association has already been given in the "Pre-Convention Bulletin" supplement to the April number of CALIFORNIA AND WESTERN MEDICINE. Since, therefore, the current issue will be placed in the mails when the meetings at Coronado are still in progress, the record of proceedings of the annual session, both in relation to the scientific assemblies (general and section meetings, scientific exhibits, and medical films) and organization or business activities (House of Delegates and Council meetings), must lie over for the June issue of the OFFICIAL JOURNAL. In the meantime, returning delegates and visitors will be able to make their oral reports to component societies.

* * *

Increasing Activities Necessitate a Larger "Pre-Convention Bulletin."—Members may have noted that the "Annual Session Program—Pre-Convention Bulletin" supplement was of larger size this year, consisting of ninety-two pages; the OFFICIAL JOURNAL proper containing only fifty-two pages of text. To some members, so large an allocation of space for a discussion of activities and policies may seem unwarranted; but such judgment must be changed if it be agreed that the story of the needs of organized and scientific medicine should be made available to each of the more than six thousand physicians who make up the California Medical Association membership. Nor should it be forgotten that, today, it is the practice of scientific medicine that is being assailed; mostly, it is true, by theorizing agencies and individuals from without the medical profession, but, nevertheless, with powerful effect and to the detriment of the prestige of the medical profession. In recent years there has never been a time when scientific medicine has so much needed the support of organized medicine than at the very present. There is ample reason, therefore, for bringing the many reports that were given place in the "Pre-Convention Bulletin" to the attention of State Association members.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Why More General Meetings Were Inaugurated at This Year's Annual Session.—In recent issues mention was made of the departure from program arrangements of previous years, whereby each morning of the four-day session was set aside for a general meeting of all members; the meetings of the twelve scientific sections being held in the afternoons. The Committee on Scientific Work, in recommending this innovation, felt that the programs of the general meetings could be made of equal interest and value to physicians, both those in general and those in special practice. Also, that the recital and discussions in the general meetings on the progress and newer work in specialty fields were desirable for physicians doing general work, just as it was good for specialists, in turn, to keep more in mind their own relation to general medicine and practice. It will be interesting to observe the reaction of members in attendance at Coronado concerning these new procedures. If favorably received, they will, no doubt, be continued.

* * *

Sunday Meetings for Accessory and Affiliated Organizations.—California, geographically considered, is a large state; on which account, both because of time and money factors, contemplated travel from place to place must usually be carefully considered by physicians. For instance, at this sixty-ninth annual session, the California Medical Association convenes at Coronado, practically on the Mexican border, in a city about one thousand miles distant from the California cities of Eureka and Yreka, adjacent to the Oregon border. Therefore, because of transportation conditions, this year's trip means practically an extra day away from practice for the majority of those members who reside north of the Tehachapi.

Which brings to mind the thought: why not emphasize the value of meetings on the Sunday which immediately precedes the opening session on Monday morning? The earnest and growing groups of members who register for the Sunday conferences in radiology and pathology give ample evidence of the desirability of such Sunday meetings, especially for physicians who can be away only a limited number of days, and who find week-end absences less disturbing in their work.

Members of the Committee on Scientific Work have also expressed the opinion that all meetings at which lectures or demonstrations are given by organizations that are not official units of the California Medical Association might well hold their major meetings on Sunday mornings and afternoons, in order to avoid conflict and overlapping with the afternoon meetings of the twelve Scientific Sections of the Association. In this connection, it must be remembered that, under the new arrangements, no Sections are permitted to hold morning meetings; and also, that Tuesday afternoon, as in previous years, is allocated for entertainment. On Sunday, meeting-room facilities are ample, but not so on other days of the session.

Attention is again called to the Sunday meetings for physicians who are interested in keeping in touch with radiologic and pathologic work. The

earnestness of those who have been attending these conferences is the best evidence of the worth of such meetings. The committees in charge of those programs will be glad to give information to physicians who are interested, and who have not availed themselves of the privileges of attendance.*

* * *

All Members Should Visit Scientific and Technical Exhibits, and Medical Film Displays.

Some comment concerning the scientific exhibits and displays of medical films would seem to be in order. It is the hope of the Committee on Scientific Work that these features may be so developed that, in the future, they will become of increasing interest and value. In this connection it is proper at this time to advise all members who contemplate exhibit or film displays for next year's annual session to make their plans now, and confer at an early date with the proper officers and committees. Likewise, members who have in mind the submittal of papers for placement on the program of the annual session to be held next year should write as soon as convenient to the Secretary of the proper Scientific Section.†

MEDICAL SERVICE LEGISLATION

Vigilance Concerning Proposed Legislation Must Not Abate.

—So long as statutes inimical to standards of scientific medicine and practice are pending in legislative halls at Washington or Sacramento, or are under serious consideration and approval of a state administration, the organized medical profession of California must continue to maintain an alert interest in proposed federal and state laws. The repeated onslaughts that have been made against the medical profession, from angles and forces not foreseen so recently as even ten years ago, and the widespread acceptance by a large number of citizens of the propagandist half-truths so ruthlessly and persistently exploited concerning supposed medical inadequacies, should convince all physicians that, in these matters, the medical profession of the United States is not confronted with a passing theory or emotional whim, but by an accomplished fact; namely that, for reasons best known to themselves, these propagandist agencies referred to have embarked on a determined campaign to bring about the enactment of so-called health and hospitalization measures which they so vociferously espouse, both on platforms and in press.

* * *

Physicians Must Be Alert to Civic Responsibilities.

—Wherefore, in order best to conserve the interests of the public health and the practice of scientific medicine, all physicians, more than ever before, should take an interest in civic matters, and be observant of candidates who aspire for office in the legislative chambers, or in the gubernatorial administrative divisions. Candidates who in the past have had affiliation with, or who, through their

* For additional information, see in "Pre-Convention Bulletin," under "Other Meetings," on page 23.

† The list of Section officers appears in each issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6.

own associations, are apt to coöperate and aid in carrying out designs of those who would bring into being laws that would radically change the nature of medical practice, from both scientific and economic standpoints, certainly should never receive the endorsement or support of physicians or other citizens who believe in sound public health principles.

* * *

Pending Legislation in U. S. Congress.—At Washington, perhaps because of the troubles overseas and the political uncertainties of a presidential-election year, the proposed national Health Bill of Senator Robert F. Wagner of New York will probably not be passed out from committee for serious discussion on the Senate floor during the present session of Congress.

Whether the hospital construction bill—also introduced by Senator Wagner and having, in addition, the cordial approval of President Roosevelt—will go on to enactment by the present Congress is more difficult to forecast.

The Journal of the American Medical Association in recent issues (April 6, 1940, on pages 1365-1377, and April 13, on pages 1457-1465) printed the record of the hearings on this Wagner-George-Lea measure (S. 2330). A perusal of the proceedings makes evident not only the divergent views of the various speakers, but also the lack of exact knowledge and figures by proponents of the measure, who, as in so much of the new legislation of nowadays, here save themselves with "objectives"; as if "theoretical objectives" were synonymous with "practical attainment of objectives." It is therefore to be hoped that this measure (S. 2330) will not be enacted in its present form.

Other federal legislation of analogous drift, such as Mr. Abraham Epstein's revised health insurance bill (S. 3660), introduced by Senator Capper of Kansas, has even less chance of passage during the present congressional session.

* * *

Political Medicine in California.—Turning now to California, it is reassuring that, up to the time of this writing, no compulsory health bill initiative has been circulated for signatures. Here again, a number of distracting forces having relation to other matters have so engrossed the attention of the gubernatorial sponsors, committees and adherents—who acted as proponents for a similar measure in the 1939 legislature of California—that, seemingly, they have come to the conclusion it may be wisest policy not to place a compulsory health initiative on the state ballot of November, 1940. If this surmise be true, so much the better, because time will permit closer study of their proposed law, and also offer greater opportunities to reveal the weaknesses of this type of "bureaucratic and political medicine."

However, the proponents may be counted on again to come to the front with similar legislation when the next California Legislature convenes at Sacramento, in January, 1941. On which account,

as before stated, members of the medical profession should this year take an active interest in legislative candidates who place their names on the ballots at the primary election.

And in all assembly and senatorial districts support should be given only to those aspirants for office who may be depended upon to stand for sound public health and sane economic legislation.

AN HISTORICAL RETROSPECT: BUBONIC PLAGUE IN 1901

A Gift from Pennsylvania.—Several weeks ago, the Librarian of The Medical Society of the State of Pennsylvania sent to the California Medical Association a copy of the *Transactions of the Medical Society of the State of California* for 1901. That year was notable in the annals of the California Medical Association, because it was the period of the bubonic plague outbreak in San Francisco, and of the reorganization of the State Medical Association.

* * *

Bubonic Plague Outbreak in California; How the Battle Waged.—In the *Transactions* referred to, the papers on Bubonic Plague, by David Powell of Marysville, S. J. S. Rogers of Marysville, and W. H. Kellogg of San Francisco, with the discussion by Dr. J. J. Kinyoun, U. S. Marine Hospital Service, covered some fifty-eight pages; wherein, speaking of the outbreak in San Francisco's Chinatown of that period, Doctor Kinyoun states:

... Another feature for preventing the spread of this disease [bubonic plague] is the Chinese fatalism and fear. When a Chinaman is quite sick, acquaintances who appear at first solicitous about his welfare become fewer and less frequent. Should the inmates of the house suspect that the person is ill with what they term "black fever" [bubonic plague], there is a general exodus, no one standing on the order of his going. In conversation with several Chinese, I am told that this is the method of procedure in China, where the disease is epidemic. . . .

Later, again, there is this from Marine Health Officer Kinyoun:

... My statements made with regard to the presence of plague in San Francisco have been fully confirmed by the report of the special commission appointed by the Treasury Department to investigate and report upon this subject. This commission, as most of you know, was composed of Drs. Simon Flexner, F. G. Novy, and Lewyillis F. Barker. The report of the findings of this commission are published for the first time in today's issue of the *Occidental Medical Times*, whose editor I am under obligations to for furnishing me with proof sheets in advance, a part of which is pertinent to the foregoing remarks. . . .

And, still further, Doctor Kinyoun adds:

... After the commissioners had forwarded their report on or about February 27 last, and when the Governor and his sycophantic editorial and political business staff had failed in preventing the coming of this commission, its organization, and preventing its investigations, it was then deemed a necessary course to prevent the publication of the commissioners' findings, or anything else relating to plague in California. It was a bitter and relentless campaign, and headed by the chief executive of a state, who, in carrying out what is believed to be a dictated policy, steeped in bribery, corruption, and threats, saw fit to devote more than one-half of his annual message to what was termed "the bubonic plague scare." . . .

Concluding with:

... Look for once at the names and vocations of the "illustrissimi viri," "the immortal five," designated to represent the health interests of this great state [California] at Washington—newspaper editors, an ironmonger, and a railroad lawyer! To these and to these alone has been delegated the task of conserving the health interest of a great city. . . .

* * *

Discussion on Whether Bubonic Plague Existed in Chinatown.—Leaving now Doctor Kinyoun's discussion and turning to page 366, where begin the "Minutes of the Proceedings of the Medical Society of the State of California at its thirty-first annual session held in the Senate Chamber of the State Capitol Building, Sacramento, April, 1901" (the State Association Secretary, whose name appears thereunder being none other than George H. Evans, M. D., now of Berkeley, and the senior living ex-president of the California Medical Association*), there will be found equally interesting comment by other speakers, as may be noted in the following excerpts:

... At the conclusion of his (Doctor Kinyoun's) remarks, Dr. W. A. Briggs of Sacramento offered the following resolutions . . . :

... *Resolved*, That we hereby demand of the Governor, and the Board of Health of the State of California, that vigilance and activity in the eradication of the bubonic plague, which medical science pronounces imperative.

Dr. James H. Parkinson of Sacramento presented the following resolutions . . . :

... *Resolved*, That the Society emphatically condemns the policy of suppression of information inaugurated in San Francisco and now being perpetuated in Washington, and demands that the plain provisions of the federal law in relation to the Public Health Reports be strictly complied with.

Later came a report of the Executive Committee of the Medical Society of the State of California:

The Executive Committee, through its chairman, Dr. Philip Mills Jones,† made a report, and, on motion duly made and seconded, the Society, by vote, decided to take it up section by section.

* * *

That portion of the report relating to the plague resolutions was first taken up and discussed as follows:

Dr. C. N. Ellinwood, *San Francisco*: It seems to me, Mr. President, and members of the Society, that, in the present state of advancement of bacteriological science; in the present knowledge of the subject of the plague; and, considering the fact that there is such great divergence of opinion upon the present disease observed in San Francisco, I believe that it would be unwise, I believe that it would be doing an act this Society would regret, to pass this resolution. . . .

... If such a disease existed there, do you think that immigration and visitation from eastern tourists would not be prevented? Do you think the hotels of San Francisco would be crowded? And yet this Society of learned men, this State Medical Society, by resolutions proposes to announce to the world, and would publish as a fact, that their conclusion is that bubonic plague exists in San Francisco. Where is the justification for such a hysterical action? It can certainly do no good to anyone. It is a

* For interesting contributions on the bubonic plague outbreak, from the pen of Dr. George H. Evans, see *CALIFORNIA AND WESTERN MEDICINE*: Vol. 49, No. 5, November, 1938, page 383; Vol. 49, No. 6, December, 1938, page 458; Vol. 50, No. 1, January, 1939, page 24.

† Philip Mills Jones founded *CALIFORNIA AND WESTERN MEDICINE*.

method which develops no good, which aids not to arrest it, if it is there, and I ask the Society to think deliberately upon this subject before passing such absurd resolutions. . . .

* * *

... Dr. Wallace A. Briggs, *Sacramento*: Thirteen months ago the investigation of plague began by the bacteriologists of San Francisco. Men of local and general reputation declared it to be plague. These were followed by men of national and international reputation, and they all declared it to be plague. Should we discuss that question here in the State Medical Society of California in the face of all this? The action may be hysterical possibly, but in the presence of so great evidence as this, I say that such action is demanded. . . .

* * *

... Dr. R. F. Rooney,* *Auburn*: I rise as a country member. Have we got the plague in our state? If so, our country towns are in danger, and our neighboring states are in danger. If it exists, as we believe it to exist from proofs shown, there is danger, and we should take precautions, and not hide our heads like the ostrich, and say that, because we cannot see our peril, therefore no peril exists. . . .

* * *

... Dr. D. W. Winterberg, *San Francisco*: Before passing any such resolutions as the one under discussion, we ought to know, first of all, whether plague has ever existed or still exists in San Francisco. Now I, for one, cannot admit the existence of said disease without convincing proof, and I challenge anyone in this hall to bring forth such proof if he can. . . .

* * *

... Dr. H. A. L. Ryfkogel,* *San Francisco*: In reply to Doctor Winterberg, I will state that from the case which died on October 16, 1901, 905 Dupont Street (name), Drs. Kellogg, Kinyoun, and myself, working independently, found isolated cultures of the plague bacillus. . . .

* * *

... Dr. Emmet Rixford, *San Francisco*: I have listened with interest to the debate on these resolutions, and it seems to me very unfortunate that the subject was brought up in the Society at all. But since the matter is already public property, it is evidently incumbent on the Society to take some action. The resolutions as presented have aroused vigorous opposition, and, even as modified by the Executive Committee, seem to me to exaggerate the condition to an extent which will, if they be passed and published abroad, do great harm and injustice to the state. The main thing is the acknowledgment of the presence of bubonic plague in California, and it is quite within the province of this Society to put itself on record as being satisfied as to that fact. In the spirit of compromise, therefore, I offer the following as a substitute for the resolutions as reported by the Executive Committee:

WHEREAS, It has been shown by our local bacteriologists, and by the Commission sent by the United States Government, that the bubonic plague has existed in San Francisco, and probably does at the present time; therefore, be it

Resolved, That the Medical Society of the State of California express its confidence that the San Francisco Board of Health, the State Board of Health, and the United States Commission will be able to watch the disease, and to take proper measures for its suppression. . . .

The above excerpts reveal an interesting sidelight on California's bubonic plague outbreak of that period.

* * *

"Objects" of the "Medical Society of the State of California."—Before leaving this volume of *Transactions*, it is of interest to quote the first

† R. F. Rooney was president of the California Medical Association in both 1905 and 1906.

* H. A. L. Ryfkogel was president of the California Medical Association in 1919.

article of the Constitution of the Medical Society of the State of California on the objects of that organization:

CONSTITUTION: ARTICLE I
Name and Objects

Section 1. This Association shall be styled the "Medical Society of the State of California."

Section 2. The objects of this Association are: To form and constitute a representative body of the regular medical profession of the State of California, to encourage the unity and harmony of the said profession throughout the State, to advance its interest as a body of citizens and a liberal profession, and to promote the advancement of medical, surgical, and hygienic science. . . .

* * *

State Medical Association Membership in 1901.—The membership report of Secretary George H. Evans, on page 358, stated that the Society, in 1901, had 262 active members, twenty-two permanent members, and twenty-one honorary members.

When the names on the membership roll are scanned, it is found that, among the 305 members above noted, 178 were in practice in San Francisco, twenty-eight in Alameda County, and thirteen in Sacramento, and that there were only twelve members who were in practice south of the Tehachapi (five of the twelve, Doctors C. L. Bard, H. Bert Ellis, Walter Lindley, H. S. Orme, and W. L. Wills later being elected presidents of the California Medical Association); while practically all of these twelve members from the southern section of the State were members of the faculty of the former College of Medicine of the University of Southern California.

In those days prior to the reorganization of the American Medical Association (reorganized on the basis of one national association, one constituent state association, and only one component unit in each county), organized medicine in California was represented by two major societies: (1) the Medical Society of the State of California, covering all the north, and (2) the Southern California Medical Society, including all the area south of the Tehachapi. In California, as in other states in the Union, the reorganization of the American Medical Association, on the basis above outlined, brought about decided improvements for both organized and scientific medicine, as is amply evidenced by the remarkable growth of the constituent state associations; the California Medical Association, for example, having today a membership in excess of 6,000.

ANOTHER HISTORICAL ITEM:
ON MEDICAL SPECIALTIES

Medicine Specialties as Forecasted Some Fifty Years Ago.—At about the same time that the volume, *Transactions of the Medical Society of the State of California*, was received, the editor had occasion to look up some articles on mineral springs and related topics, from the pen of Dr. Joseph P. Widney of Los Angeles, who is celebrated in the annals of California medicine as the founder of the Los Angeles County Medical Association, the College of Medicine of the University of Southern California and the *Southern California*

Practitioner. In the May issue of Volume II of the *Southern California Practitioner* for 1887 (printed more than fifty years ago) will be found a delightful editorial from the Doctor's pen on "Specialism Run Mad," some excerpts from which, as follows, are still worthy of note:

SPECIALISM RUN MAD

It is beginning to be a question what is to be the end of the mania for specialties in medicine. We have been wont to smile somewhat at the practice of our long-queued brethren of the Middle Flowery Kingdom, where one man takes medical charge of the brain, another of the stomach, another of the bowels, yet another of the heart, and so on through the anatomical list; yet a glance at our medical journals, or at the cards of physicians in the columns of a popular paper, rather extracts the twist from the smile. . . .

Passing on, Doctor Widney continues:

. . . Possibly in that coming day, when the sick man's list of medical attendants shall only be limited by the number of separate organs to the human body, some youthful scion of a specialist progenitor shall exhume from the cobwebs of the old garret some moth-eaten book upon general practice, and with a look of vague wonder upon his countenance shall inquire as he turns over its unfamiliar pages the meaning of it all, and shall receive for reply some such answer as this: "This, my son, is an old heirloom, handed down from a distant ancestor, who in the dimness of the past practiced some rude sort of healing art. It is said, my son, that instead of, like myself, making a specialty of some such department as diseases of the distal phalanx of the little finger, he even professed to treat diseases of the human body in general. It was a primitive age, my son, an age when such an erudite work as my three volumes upon congenital peculiarities in the anatomy of the nail of the little finger would not have been appreciated. Such refinements of science, my son, were as yet beyond their crude ways of thought. . . .

And, finally, Doctor Widney says:

. . . How shall he be narrow and broad at the same time?

. . . Brethren, the editorial head has it. Specialize everything. It does not claim originality in the idea. It caught the thought from the card of a physician who advertised twelve specialties besides surgery and general practice.

. . . Vive la specialty! . . .

Had the above expressions come from a lesser seer* than this remarkable man, who maintained his literary and other activities up to the age of 96, they might have been passed by without notice. Emanating, however, from him, his prognostications may still afford reason for pondering.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 232.

* Biographical sketches of Joseph Pomeroy Widney appeared in *CALIFORNIA AND WESTERN MEDICINE* in the following issues: Vol. 44, No. 4, April, 1936, page 292; Vol. 44, No. 5, May, 1936, page 396; Vol. 46, No. 6, June, 1937, page 398; Vol. 49, No. 2, August, 1938, page 106, editorial, *Passing of Joseph P. Widney*, Founder of the Los Angeles County Medical Association; Vol. 49, No. 2, August, 1938, page 161, *Obituary*.

The routine use of the tuberculin test in prenatal care can be easily used in clinics and private practice for discovery of active tuberculosis. Unsuspected active tuberculosis occurred in 1.7 per cent of those tested in one county in California where the early institution of collapse therapy prevented extension of the pulmonary disease.—Charles Ianne, *Amer. Rev. of Tuber.*, Dec., 1939.

EDITORIAL COMMENT†

RUPTURED INTERVERTEBRAL DISC:
AN UNFINISHED PROBLEM

Recently a wave of enthusiasm favoring laminectomy for severe sciatic pain has swept the country. Indeed, one well-known surgeon has said that ruptured intervertebral disc was a common cause of sciatic pain.¹ Excellent results have been described following laminectomy for ruptured intervertebral disc.² It is well to review several of the procedures that have been performed in the past for sciatic pain, and to append the reported percentage of good results from each procedure.

Procedure	Excellent or Good Results (Per Cent)	Author
Ober fasciotomy	75	Smith ³
Lumbosacral fusion	72	Ghormley and Wesson ⁴
Epineural sacral injection	66	Whitaker ⁵
Heat and electrotherapy	90	Schmidt and Smith ⁶
Intravenous injection of sodium salicylate	100	Sutton ⁷
Heyman fasciotomy	76	Heyman ⁸
Manipulation	87	Freeman ⁹
Novocaine injection to sacroiliac joint	60	Haldeman and Soto-Hall ¹⁰

Horowitz¹¹ has shown that in a series of twenty-five cadavers, posterior herniation of the intervertebral disc into the spinal canal occurred in nine cases. On reviewing the histories of these cases, Horowitz found no complaint of sciatica and that backache was an infrequent and minor symptom. Schmorl¹² had previously pointed out the frequency of intervertebral disc variations in cadavers.

Despite the evident relief afforded many patients by excision of a ruptured nucleus pulposus, some

patients are unable or unwilling to resume their work following the procedure.¹³

One must realize that many structures of the back are altered by a laminectomy. Muscles and fasciae are severed and manipulated with retractors. Articular facets may be excised. It is possible that in some "cured" cases relief from pain is afforded by these procedures rather than by enucleation of the ruptured intervertebral disc. Moreover, Love² admits that pressure from a ruptured disc may subside, and thus a patient cure himself. Furthermore, the mortality following laminectomy by excellent surgeons for disc and ligamentum flavum lesions may be as high as 5 per cent.¹⁴

From the statements above one is led to the conclusion that the intervertebral disc lesion is not a closed chapter in our knowledge of sciatic pain.

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LACTATION IMMUNITY

Some of the present confusion, in reference to the alleged rôle of colostrum in the transfer of specific immunity to infants, may be dissipated by the immunogenetic studies recently reported by Schneider and Szathmáry¹ of Budapest, Hungary.

From the immunogenetic point of view, domestic animals may be divided into four main groups, depending upon the type of placentation. In horses, swine, cattle, and other animals of Group I, the maternal and fetal circulations are separated by seven distinct layers of tissue through which antibody transfer must take place. Both the maternal epithelium and the chorionic epithelium are intact in this group, the two epitheliums being separated by a thin layer of colloidal secretions. In the sheep and other animals of Group II, the uterine epithelium and the layer of secretion are both absent, the chorionic epithelium being in direct contact with maternal connective tissue. In the dog and other animals of Group III, this intervening connective tissue layer is also absent, the chorionic epithelium coming in direct contact with the outer walls of the maternal capillaries. In man, anthropoid apes, rabbits, and other members of Group IV, even this capillary endothelium is lacking, the chorionic epithelium coming in direct contact with the maternal blood.

One would expect from these differences that transplacental transmission of antibodies would be least effective in Group I, and that the new-born of this group would have to rely mainly on lactic transfer of specific antibodies. Prenatal transfer of antibodies would, presumably, become more effective as one passes to the higher groups, the most effective transfer presumably taking place in members of the fourth group. In order to confirm these deductions, the Budapest clinicians injected

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Love, J. Grafton: *Proc. Staff Meet., Mayo Clin.*, 14:50-800 (Dec. 13), 1939.

² Love, J. Grafton: *Protruded Intervertebral Discs*, J. A. M. A., 113:2029-2035 (Dec. 2), 1939.

³ Smith, A. D.: *Results of Fasciotomy for Relief of Sciatic Pain*, J. Bone & Joint Surg., 19:765-769 (July), 1937.

⁴ Ghormley, R. K., and Wesson, H. R.: *Surgical Treatment of Low Back Pain and Sciatica*, South. M. J., 30:806-811 (Aug.), 1937.

⁵ Whitaker, P. F.: *Treatment of Sciatica by Epidural Sacral Injection*, Virginia M. Monthly, 60:489-491 (Nov.), 1933.

⁶ Schmidt, W. H., and Smith, J. L.: *Sciatic Syndrome and Its Management*, Arch. Phys. Therapy, 20:494-500 (Aug.), 1939.

⁷ Sutton, H. B.: *Intravenous Injection of Sodium Salts in Sciatica*, Lancet, 237:1168 (Dec. 2), 1939.

⁸ Heyman, C. H.: *Posterior Fasciotomy in Treatment of Back Pain*, J. Bone & Joint Surg., 20:851-859 (Oct.), 1938.

⁹ Freeman: *Remarks and Statistical Analysis of One Hundred and Forty Cases of Sciatica Treated by the Method of Stretching and Immobilization*, Orthopedic Research Seminar Notes of University of Iowa, Series IX, 1935, Section C, page 48.

¹⁰ Haldeman, K. O., and Soto-Hall, R.: *Diagnosis and Treatment of Sacro-iliac Conditions by Injection of Procaine (novocain)*, J. Bone & Joint Surg., 20:675-685 (July), 1938.

¹¹ Horowitz, Thomas: *Lesions of the Intervertebral Disc and Ligamentum Flavum of the Lumbar Vertebrae*, Surgery, 6:418-422 (Sept.), 1939.

¹² Schmorl, G.: Quoted by Horowitz, T. See No. 11.

¹³ Willems, J. D.: *Discussion of Intervertebral Disc Lesions*, J. A. M. A., 114:2034 (Dec. 2), 1939.

¹⁴ Bradford, F. K., and Spurling, R. G.: *Intraspinal Causes of Low Back and Sciatic Pain*, Surg. Gynec. & Obst., 69:455 (Oct.), 1939.

¹ Schneider, L., and Szathmáry, J.: *Ztschr. f. Immunitätsforsch.*, 94:453, 465, 1938; 95:169, 177, 189, 465, 1939.

pregnant or pre-pregnant members of each group with two antigens, B. typhosus and diphtheria toxoid. Serum, colostrum, and milk from these immunized animals were titrated for typhoid agglutinins and diphtheria antitoxin shortly before delivery. A parallel titration was made of the serum of the young, both at the time of birth and after normal colostrum or milk feedings.

In animals of Group I (calves) the antibody titers of both maternal blood and colostrum were high. The young of this group were born with practically no trace of this acquired specific immunity. A rapid increase in antibody titer took place in new-born blood, however, following the first colostrum feeding. In Group II (sheep) an appreciable trace of maternal antibodies was demonstrable in new-born serum, increasing sharply after the first colostrum feeding. In Group III (dogs) a 33 per cent transfer of maternal antibodies was demonstrable in new-born blood, with a 100 per cent increase in this fetal titer after colostrum feeding.

Of direct clinical interest are their data from Group IV, which has the same type of placentation as man. Here the antibody titer of the new-born (rabbits), was very nearly identical with that of the mother. In place of an increase in fetal titer a 10 per cent drop in new-born titer took place as a result of the first colostrum feeding. The general conclusion from these data of the Hungarian investigators is that in animals of Group IV, (including man), the transfer of specific antibodies from mother to young is solely by the placental route, lactation immunity being nonoperative in this group.

From the theoretic point of view the apparent total lack of absorption of colostrum antibodies from the gastro-intestinal tract in rabbits is the most suggestive part of this contribution from Budapest by the Hungarian investigators. The reason for this apparent nonabsorption has not been determined. A 100 per cent absorption takes place in calves. If, as they assume, a similar lack of antibody absorption from the gastro-intestinal tract takes place in man, many of the current arguments in favor of breast-feeding of infants and arguments against pasteurization of milk will have to be revised.

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Adult Human Pulse Rate Is Variable.—"The adult human pulse rate is considerably more variable than many persons think," *Hygeia, The Health Magazine*, declares.

"Extensive and exact studies of the measurement of the heart rate of persons in New York City have shown pulse rates ranging from fifty-five to 120 beats per minute in a healthy person in a normal twenty-four hour cycle."

Chronic Nonspecific Pulmonary Disease is complex and confusing both clinically and anatomically. An increase in the density of the pulmonary markings, ring shadows, the displacement of organs or chronic pneumonia should arouse the suspicion of bronchiectasis.—Paul Andrus, M.D., *American Review of Tuberculosis*, January, 1940.

ORIGINAL ARTICLES

SYPHILIS: ITS TREATMENT IN THE TUBERCULOUS PATIENT*

By WALTER BECKH, M. D.
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FOR many years the frequent coexistence of the two most prevalent chronic infectious diseases, namely, syphilis and tuberculosis, has raised numerous issues. Since the advent of Thomas Parran as Surgeon-General of the United States, greater efforts are being directed toward the eradication of syphilis, and this disease is now beginning to receive the attention, from the public health point of view, which it deserves. It appears timely, therefore, to review some of the problems involved in the treatment of the patient who has pulmonary tuberculosis, but who is also ill with syphilis.

GENERAL CONSIDERATIONS

Not only tuberculosis, but also syphilis is one of the greatest killers of mankind. It is somewhat surprising, therefore, that in the past the discovery of syphilis in a tuberculous patient has not aroused the concern it merited when the health of the patient was considered from the long point of view. This has been due, in part at least, to the fact that the patient with tuberculosis has usually been confined to an institution staffed by physicians primarily interested in tuberculosis. The physician in the sanatorium is confronted with a situation in which he has to deal with two disease entities, the tuberculosis usually being the more overt one of the two. It is little to be wondered, therefore, that the tuberculous infection has usually been considered of primary importance. This is, however, not necessarily so, because, as the success of our therapeutic measures against the ravages of the tubercle bacillus is increasingly prolonging the life of the patient with tuberculosis, the problem of organic disability and dysfunction due to the late effects of syphilis is assuming an increasingly important rôle. We know that certain forms of syphilis, such as paresis and cardiovascular syphilis, are more surely fatal than even exudative tuberculosis, and tabes dorsalis and other forms of neurosyphilis are equally more surely productive of chronic invalidism than tuberculosis. If to these forms of frankly grave syphilis we add other potentially serious forms, such as asymptomatic neurosyphilis, the array of syphilitic conditions which may kill the patient after he has been cured of his tuberculosis becomes quite formidable. The greater number of patients in tuberculosis institutions are under the age of forty. In syphilis, the eventual serious outcome, however, usually does not become manifest until after the fourth decade of life. Therefore, if we give adequate antisyphilitic treatment to the patient at a time when his syphilitic infection has not yet caused irreparable damage to vital organs,

* From the Department of Medicine, Stanford University School of Medicine.

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we can entertain sincere hopes to prevent rather than to palliate.

Another important point which has not been stressed nearly enough is that the patient with co-existent tuberculosis and syphilis is a public health menace from the point of view of both diseases. This problem becomes particularly acute in a tuberculous patient who also has early and infectious syphilis. To quote Padget and Moore:¹ "In recent syphilis, with infectious lesions actually or potentially present, noninfectiousness must be promptly achieved, even at some risk to the individual patient. This is particularly true, since in actual practice the tuberculosis sanatoria . . . are so crowded that a delay of weeks, or even months, after the diagnosis may ensue before hospitalization and isolation can be accomplished. Under these circumstances, it is imperative that early syphilis be rendered noninfectious as early as possible."

DIAGNOSIS

The diagnosis of syphilis is made on the basis of clinical or serological criteria, or both. In the tuberculous patient the additional diagnosis of syphilis is, in the majority of instances, made by the serological findings alone. A positive Wassermann reaction or one of its modifications is usually interpreted as indicating the presence of syphilis, but there are without question false positive or doubtful reactions occurring in diseases other than syphilis. Inasmuch as tuberculosis has been one of the diseases frequently included, it is to the point to examine more closely the question of the false positive Wassermann in tuberculosis.

Eagle² and others have pointed out that an unchecked positive Wassermann in a person with no history or sign of syphilis, in the presence of another disease, need not indicate the presence of syphilis. Rather, the positive serological test may be due to faulty laboratory procedure, to an anomalous property in the serum similar to that found in rabbit serum, or to the presence of reagin. The first of these, laboratory error, should be recognized easily by consistently negative follow-up tests. If, on the other hand, both a complement-fixation test and a flocculation test are repeatedly positive, the presence of reagin is definitely indicated by this. Stokes³ has felt that tuberculosis should be placed in the "disputed" group as regards its influence on the specificity of the serodiagnostic tests. New light has been thrown on the situation by a recent study of Parran and Emerson.⁴ Their conclusions, from a large number of tests conducted in the laboratories and under the supervision of five serologists who have all developed their individual serodiagnostic tests, seemed to prove that tuberculosis may contribute a confusing factor to syphilis serology, although this is an infrequent occurrence. As one might perhaps expect, this effect of tuberculosis manifests itself in those tests found to be the most sensitive. The conservative conclusion must be that, with the present serological tests, false-positive and false-doubtful results may be obtained, although infrequently, in sera from patients with tuberculous disease.

When the diagnosis of syphilis has been made and the disease is clearly not of recent origin, further procedures must be employed to establish, if possible, the presence of obscure forms, such as cardiovascular syphilis or neurosyphilis. This must be done not merely to satisfy one's scientific curiosity, but also to aid one in outlining the subsequent antisyphilitic treatment. While in many cases it will make no difference whether these diagnostic procedures are deferred even for a considerable time, there are some patients in whom early diagnosis of neurosyphilis may be of great consequence for their future well-being. It is well, therefore, as a matter of general policy, to investigate the cardiovascular system and the central nervous system as soon as possible. It is needless to say that the seriousness of the patient's general condition determines at what moment the necessary diagnostic measures can be carried out with safety.

TREATMENT PROCEDURES OF TUBERCULOSIS AND SYPHILIS, AND THEIR MODIFICATION BY THE PRESENCE OF THE OTHER DISEASE

In a patient with both tuberculosis and syphilis, it is true, generally speaking, that the treatment of the tuberculosis is unaffected by the fact that the patient also has syphilis. While his antisyphilitic treatment should be considered from the angles which will be enumerated in due course, the patient is usually given the same therapy he would receive for his tuberculosis if it were not complicated by syphilis, be it bed rest, pneumothorax, or even surgical procedures. There are two exceptions to this rule. One is the presence of syphilis in the infectious stage, which should be a temporary contraindication to surgical measures, particularly inasmuch as there is usually no cause to carry these out with great dispatch. The other exception occurs in the rare patient who presents himself with a combined picture of tuberculosis and general paresis. Here the latter usually carries with it a more acute danger to the patient's life than do most tuberculous cases, and therefore requires early treatment.

It is plain that hard-and-fast rules for the treatment of syphilis in a given instance cannot be made, and that the various factors involved in the individual case have to be weighed. Obviously, a patient with an old latent syphilitic infection, and a rapidly spreading extensive, tuberculous process presents a different problem from one with a combination of stationary old fibroid tuberculosis and early infectious syphilis. The solution of such problems presents difficulties, but a more detailed consideration of the antisyphilitic drugs should aid in unriddling them.

Arsenical Medication.

The usual method of treatment of uncomplicated syphilis involves the use of courses of a trivalent arsenical drug, given in alternation with courses of a heavy metal. Many physicians add to this one of the iodids, usually in the form of potassium iodid. In certain forms of neurosyphilis, tryparsamid is also used, and some cases of neurosyphilis have to be given fever therapy.

There is a uniformity of opinion that drugs of the salvarsan series are indispensable in the armamentarium of him who is treating infectious syphilis. However, there is no uniformity of opinion regarding the use of the arsphenamins in the tuberculous patient. There is a group who believe that trivalent arsenicals have no deleterious effect, even when used in large doses, but there is an equally large group who feel that *big* doses of an arsphenamin, at least, potentially produce activation of a latent tuberculous focus and may facilitate hemoptysis or even provoke a miliary spread. The latter contention does not rest on a firm scientific basis, and it is questionable whether it will ever be satisfactorily answered.

To get around this difficult question by giving an oral arsenic preparation such as stovarsol, as Schlesinger⁵ has done in some of his cases, is ignoring what we know about this pentavalent drug. Robinson and Robinson⁶ have again pointed out that it is dangerous and contraindicated in the treatment of syphilis in the adult.

There is, however, some reason for the belief that neoarsphenamin and mapharsen are safer drugs to use in the tuberculous patient than old arsphenamin. The conclusion is justified that the use of neoarsphenamin and mapharsen is quite safe even in the patient with moderately advanced tuberculosis, if the dose is held at a moderate level, say, not above 0.45 gram per weekly injection of neoarsphenamin or 0.04 gram of mapharsen. Continued hemoptyses or rapid progression of the tuberculosis should lead one to abandon the use of the arsenicals temporarily.

Iodids.

As regards the use of the iodids, most of us have been brought up on what seems almost like an empiricism now; namely, never to use iodids in a patient with active pulmonary tuberculosis. Although Schlesinger⁷ has advocated the use of iodids in the treatment of late syphilis occurring in combination with any but florid tuberculosis, conservative principles of therapy should rule out the use of the iodids. This is not of great moment, however, since the chemotherapeutic advances of the past two decades have relegated the iodids to a very minor position in the armamentarium of antisyphilitic drugs.

Heavy Metals.

In the matter of the heavy metals, such as the bismuth and the mercury compounds, there appears to be no contraindication to the use of any, with the possible exception of iodobismutol. It will be recalled that iodobismutol contains sodium iodid. The quantity of iodid is quite small, however, indeed so small that if iodobismutol is given in a dosage of two cubic centimeters twice a week, the iodid introduced into the body is equivalent to no more than ten drops of a saturated solution of potassium iodid. Although no laboratory or clinical studies are available on this point, it is unlikely that ten drops of a saturated solution of potassium iodid per week is a sufficiently large amount to

produce adverse effects even on moderately advanced tuberculosis.

Fever Therapy.

There remain for consideration the two procedures most commonly employed in the treatment of neurosyphilis. Fever therapy is a measure generally used in paresis and sometimes in the treatment of tabes. Little work has been done on the effects of artificially induced fever on pulmonary tuberculosis, but the opinions as to possible deleterious effects have been controversial.⁸

It would seem that the use of a treatment method such as fever therapy, with its attendant upsetting and generally strenuous features would be indicated only when the results of such a method are very striking and when the indications for its use are urgent. This obviously is the case in a combination, fortunately rare, in which a tuberculous patient also has paresis. Here fever therapy is indicated in any but the moribund patient. Patently, what would be the point of treating only his tuberculosis, delaying the fever therapy until it is too late, only to have him, at best, eke out an unprofitable demented or psychotic existence? Which form of fever therapy is used would seem to matter little, although the use of one such as typhoid vaccine involves perhaps a somewhat smaller risk.

Tryparsamide

The other important approach to the therapy of neurosyphilis is the use of tryparsamide. There is little evidence to show that tryparsamide has any ill effect on the tuberculous patient. This is as one would expect on theoretical grounds, because tryparsamide has no action on the capillary system and does not influence fibrosis. Besides, upsetting treatment reactions are infrequent. Taking the proper precautions against its toxic effects on the optic nerve, its use should be more extensive than it is at present. In coexistent tuberculosis and neurosyphilis it should be a particularly valuable adjunct to antiluetic therapy.

IN CONCLUSION

After this somewhat detailed consideration of antisyphilitic treatment procedures and drugs, the course to be pursued in the therapy of the individual case becomes a less complicated matter. It has become evident that, generally speaking, in coexistent tuberculosis and syphilis the patient, rather than his diseases, must be treated. With the exceptions noted, the treatment of tuberculosis is unaffected by the presence of syphilis. It is plain that uniform directions for the treatment of the syphilitic infection cannot be given. In the average case of tuberculosis adequate treatment of concomitant syphilis along standard lines is justified, when the drugs—particularly the arsphenamins in the form of neoarsphenamin or mapharsen—are employed in moderate dosage, because progression of the tuberculosis is not likely to be more frequent in patients so treated. In active and recent syphilis, treatment is imperative from the public health standpoint alone. Usually the active pulmonary

processes are the more pressing, but as soon as syphilis has been diagnosed, the syphilitic status must be properly evaluated and a program for its therapeutic consideration formulated.

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ARTHRITIS: ITS TREATMENT WITH UNDENATURED BACTERIAL ANTIGENS

By DOROTHY WALSH SCHALLIG, M. D.
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THE writer's introduction to the use of undenatured bacterial antigens¹ in the treatment of arthritis was indirect. A patient who had been operated on for perinephritic abscess ran a post-operative course complicated by excessive drainage from the wound. Since both staphylococci and streptococci were isolated from the pus, a course of eight intradermal injections of staphylococcus-streptococcus undenatured bacterial antigen consisting of 0.5 cubic centimeter each, was administered. This patient had had arthritis of the right knee for five years previously and had been given injections of various types of vaccine in addition to physiotherapy, rest, etc., without improvement. After the eighth injection of undenatured bacterial antigen, the patient volunteered the information that she no longer had any pain or stiffness in her knee. As this was the only form of treatment given, it was concluded that the antigen solution must have contributed to the clearing up of the arthritis, and it was decided to try the same therapy on arthritic patients presenting themselves for treatment to the Sacramento City Clinic, as well as the Sacramento County Hospital Clinic and the Women's Ward.

All patients whose major complaints were joint pain and stiffness received injections of staphylococcus-streptococcus undenatured bacterial antigen. While occasional patients had the benefit of an x-ray examination, for the most part the symptomatology and physical signs were relied on for the diagnosis of chronic arthritis. A total of between 300 and 400 patients were treated with antigen injections, but at the time no thought was given to reporting on this form of treatment. Neither clinic has a cross-index system based on

TABLE 1.—Age Distribution and Duration of Symptoms Before Treatment in Series of One Hundred Patients With Arthritis

Age Groups	Number of Patients	Duration of Symptoms	Number of Patients
Under 20 years	4	Under 3 months	19
20-30 years	2	3 mos. to 1 year	27
30-40 years	18	2 years	10
40-50 years	24	3 years	6
50-60 years	20	4 years	5
60-70 years	24	5 years	8
Over 70 years	8	6 years	4
		10-15 years	12
		20-40 years	9

diagnosis; therefore, many of these case records are inaccessible, and the present report deals with only one hundred random cases whose records were available.

Duration of symptoms in this group varied from less than three months to as long as forty-five years, and the ages of the patients ranged from seventeen to seventy-six years. (Table 1.)

The treatment routine comprised administration of 0.5 cubic centimeter of staphylococcus-streptococcus undenatured bacterial antigen, given intradermally twice a week. Since the amount of fluid was larger than the average intradermal dose, it was found desirable to use a 22-gauge intravenous needle, and injections were made with the needle nearly parallel to the skin. Some local redness was observed following the injections, but this disappeared rapidly and occasioned no serious discomfort. No palliative or symptomatic treatment was given during the period of antigen therapy in order that any change in symptoms could be more clearly evaluated.

Improvement, as noted by relief of pain, was observed early in the course of treatment in the majority of cases. Relief of all symptoms was obtained in 47 per cent of the patients within five weeks after beginning treatment, *i. e.*, following administration of ten injections of undenatured antigen solution. An additional 18 per cent were relieved in five to ten weeks of treatment, while 28 per cent required ten to twenty-five weeks for abatement of all symptoms. Only 7 per cent of the patients failed to show any improvement during treatment.

COMMENT

The treatment of chronic arthritis with undenatured bacterial antigen is well adapted to clinic practice where facilities for intensive investigation of each individual patient are lacking and where the diagnosis must necessarily be made on the basis of symptomatology and physical signs. The solution is given intradermally twice a week; there are no systemic reactions, and the procedure is decidedly economical as compared with intravenous vaccine therapy. Even with cases of long duration, relief has been obtained quite early in the course of

TABLE 2.—Total Injections of *Staphylococcus-Streptococcus* Antigen Required for Relief of All Symptoms in Series of One Hundred Patients With Arthritis

Number of Injections	Number of Patients Symptom-free
10 or less	47
10-20	18
20-50	28
Unimproved	7

the treatment, and very few of our cases have required more than twenty injections, *i. e.*, ten weeks of treatment. The series reported on represent patients selected at random from the case files of the Sacramento City Clinic, the Sacramento County Hospital Clinic, and the Women's Ward in the County Hospital. The writer is well aware of the difficulty of evaluating any method used in the treatment of chronic arthritis; but on the basis of a considerable experience in this field the results obtained, following the administration of undenatured bacterial antigens, have been outstanding. There exists a reasonable rationale for the method if one grants the premise of Wherry,² Krueger,³ Fuendeling,⁴ and others, that arthritis, like many other chronic states, represents the end-result of long-continued tissue sensitization due to absorption from infectious foci. In the studies of Krueger and of Fuendeling, most of the patients suffering from chronic arthritis have had a mixed flora containing both streptococci and staphylococci. Large numbers of various strains of these organisms are contained in the undenatured bacterial antigen solutions, and they are present in a readily absorbable form, *i. e.*, in solution, and in the form of colloidal suspended cell fragments. Logically, the solution could be expected to serve very well as a desensitizing agent. That it accomplishes this aim is evident from the writer's clinical experience: there were only seven failures out of one hundred treated cases.

The intradermal injection of the antigen solution has been employed because of the observation by several different workers⁵ that the immune response following intradermal injection is considerably better than that obtained with subcutaneous injection. In a personal communication, Doctor Krueger has informed me that the clinical response, as well as the humoral antibody titer, has been definitely shown to be better in several different series of observations on undenatured bacterial antigens given by the intradermal route.

REPORT OF CASES

In order to demonstrate the type of response obtained, a few typical case reports are given below:

CASE 1.—M. P., American, male, peddler, age 63.

Complaint.—Pain in right hip, knee and ankle of two months' duration; worse with motion. Patient could not walk without crutches, and had great difficulty in locomotion even with crutches.

Physical examination and laboratory tests revealed nothing of interest, with the exception of functional limitation in joints of the right hip, knee, and ankle.

Treatment.—Five-tenths cubic centimeter of staphylococcus-streptococcus undenatured bacterial antigen was given intradermally at the patient's first visit. Five days after this, and one day after the second injection of antigen, patient noted a marked decrease in pain. When he returned a week later for a continuation of treatment, he was using only one crutch. Two weeks after the institution of treatment the pain had practically disappeared and he was walking without crutches. Within six weeks, *i. e.*, after twelve injections of antigen, the patient was discharged with no pain or stiffness in the joints.

CASE 2.—A. A., American, male, age 19. Five years before entry the patient had had an infection of the fifth left toe, which was treated with hot baths and glycerine and alcohol compresses. The lesion drained for four months. About a year later there was an infection of the upper lip and a general scarlatiniform rash. Eleven months following this the patient had a boil on the neck, which was opened and drained. A month later there was a cellulitis with right femoral adenitis. After a month of treatment the patient was discharged.

Complaint.—Five years following the initial infection in the left toe the patient noted stiffness and enlargement of the wrists, ankles and all the phalangeal joints. He had not been able to close his hands for the past six months. The motion was not painful, but there was distinct tenderness to pressure over the joints. He states that the joints have been gradually enlarging over a period of two years.

Physical findings, except for the enlargement of the joints, were essentially negative. The customary dosage of 0.5 cubic centimeter of staphylococcus-streptococcus undenatured antigen was given by the intradermal route twice a week. Within two months the patient could completely flex the fingers, and the joints were noticeably decreased in size. The patient said he felt better generally than he had in the past five years. Six months after the institution of antigen therapy the joints were practically normal in size; there was no limitation of motion and the patient no longer complained of stiffness.

CASE 3.—M. P., American, female, age 53.

Complaint.—Pain in lumbar region for the past five years; patient unable to bend or to accomplish any movements involving the lumbar spine. Large doses of aspirin had given some temporary relief. Patient has a long history of treatment by qualified and unqualified practitioners.

Physical examination revealed limitation of motion in the lumbar spine with no other significant findings. The x-ray diagnosis was chronic lumbosacral arthritis. Seven intravenous injections of stock arthritic vaccine produced no improvement. The patient was then given a course of treatment with staphylococcus-streptococcus undenatured antigen. After the fourth injection there was less muscle spasm, and following nineteen intradermal injections of antigen there was complete relief from pain and stiffness. There has been no return of symptoms in eighteen months.

CONCLUSIONS

Staphylococcus-streptococcus undenatured bacterial antigen has been used in the treatment of one hundred patients suffering from chronic arthritis. The antigen has been administered in quantities of 0.5 cubic centimeter intradermally twice a week without any other form of treatment. Only seven patients out of one hundred treated have failed to benefit. Sixty-five per cent of the patients were completely relieved of their presenting symptoms within ten weeks of instituting antigen therapy. An additional 28 per cent required from ten to twenty-five weeks of antigen administration before attaining a favorable result.

Injections of the staphylococcus-streptococcus undenatured antigen are not followed by any systemic reactions; its use is economical, and favor-

able results are obtained rapidly in the majority of cases.

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EIGHTH NERVE AND CONDUCTION DEAFNESS*

By GRANT SELFRIDGE, M.D.
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THE recognition of deafness, with its differential diagnosis, its etiology and treatment, is a subject of paramount importance in the otological world today.

Sufficient evidence has already been offered¹ to show that there are many diseases involving the general nervous system and the peripheral nerves, the etiology of which in the past was unknown, but which are now definitely recognized as being related to nutritional deficiencies. The auditory nerve is a peripheral nerve—one of the most vulnerable in the body—and it should, therefore, show an earlier and greater damage than peripheral nerves elsewhere.

Recently a book on "Nutrition and Physical Deformities," by Price, is quite to the point and shows that defective teeth, high palatal arches, deviated septum, etc., came when primitive peoples had fed their offspring on the diets of modern civilization, *i. e.*, excessive use of white flour and sugar products (marmalades, jellies, and candy). It is well known that certain teeth and the petrous bones develop at the same time in fetal life, and as one type of deafness (otosclerosis) is related to many of the factors concerned in the metabolism of bone, the above preliminary comments are not out of order.

A recent survey of nine thousand individuals in twelve American cities by the United States Public Health Service² in Washington shows that 50 per cent are hard of hearing in varying degrees, and that quite a large number of the age of ten and younger show beginning loss at the upper end of the tone scale, while individuals beyond the age of twenty show increasing loss over each decade of life.

Most deafened individuals apparently do not understand that there is a definite difference between deafness due to degeneration of the auditory nerve and conduction deafness due to adhesive bands involving the three small bones of the middle ear, atrophy, and contraction of muscles controlling the action of the drum, or bony changes in

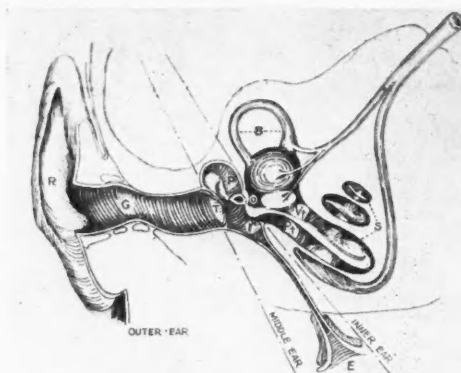


Fig. 1.—Semidiagrammatic section through the right ear (Czernak): G, external auditory meatus; T, membrane tympani; P, tympani cavity; o, fenestra ovalis; r, fenestra rotunda; B, semicircular canal; S, cochlea; Vt, scala vestibuli; Pt, scala tympani; E, eustachian tube; R, pinna.

the temporal bone at the foot plate of the stapes (otosclerosis).

That a better understanding is desirable, especially by the physician, was emphasized in an article by the author, and picked up by the Associated Press in June, 1939. A flood of inquiries and a large number of patients came from all parts of the country. This article referred only to eighth nerve (auditory nerve) deafness, and the use of thiamin chlorid and nicotinic acid. The original paper stated specifically that the final chapter to the story has not yet been written, and that much study is still necessary in regard to the vitamin B complex, particularly when the Agnes Fay Morgan's gray hair factor becomes available for experimental work, as well as other vitamins. Morgan's animals deficient in the filtrate factor of the vitamin B complex show histologically many of the signs of aging as observed in human beings. The studies of Professor Herbert M. Evans on vitamin E deficiencies already show an astonishing amount of degeneration of the peripheral nerves as well as the degeneration of the general nervous system of their experimental rats. Much is expected in the way of relieving many symptoms complained of by women having evidence of menstrual difficulties, especially at the menopause, and may prove that vitamin E will be of inestimable value as an additional substance in the treatment of hearing difficulties.

Despite the fact that this report concerned chiefly those cases showing the nerve deafness curve, about 80 per cent of the cases that presented themselves subsequently for examination and treatment were in the conduction classification, many with associated nerve involvement.

Dr. Samuel Crowe,³ Chief of the Nose and Throat Department at Johns Hopkins Hospital in Baltimore, has stated recently that the cause of atrophy of the auditory nerve was unknown. Curiously, Doctor Crowe made the following statement in his Harvey lecture:⁴ "The ear, like the eye, is a highly specialized sense organ, and is probably affected by general systemic disorders. As regards the rôle of vitamins and dietary insufficiencies, and

* From the Harriman Research Laboratories of the Southern Pacific General Hospital, San Francisco.

Read before the Pacific Association of Railway Surgeons, in San Francisco, on September 29, 1939.

the use of salicylated and other drugs in the etiology of deafness, it is possible to learn much by the feeding of animals with special diets, testing the transmission of sound and finally making serial sections of the middle and inner ear of these animals for histological study (Harvey Lectures, 1931-1932)." These suggestions of Doctor Crowe as regards the eighth nerve were not followed out due to lack of sufficient research funds.

In a more recent article (*The Journal of the American Medical Association*⁵) on the treatment of deafness, Doctor Crowe says that the loss of high tones is a common finding in children; that the majority are deaf because of obstruction of the eustachian tube, the result of infectious lymphoid hyperplasia around the tubal opening. He treats these patients with radium, but corrects at the same time dietary, environmental, and other factors. He is emphatic in his statement that the majority of deafened adults are the result of the above-mentioned conditions, and that if treatment were undertaken before the age of fifteen "the number of deaf adults in the next generation could be reduced 50 per cent."

OUR RECENT LABORATORY STUDIES

Most of this work has been based on the twenty-four-hour urinary output of thiamin chlorid and porphyrin. The laboratory studies for thiamin were carried on in the Harriman Laboratories by R. K. Main; the porphyrin studies by Jesse L. Carr in his own laboratory.

In nearly 100 per cent of the cases, the vitamin B₁ output was below normal and in approximately 50 per cent the cases showed increased porphyrin. The latter substance has been found to be universally present in pellagra; hence proof that the use of nicotinic acid is indicated. Therefore, our practice in recent months has been to prescribe thiamin chlorid (1,000 I. U.), nicotinic acid (grains one), and milk sugar (q. s. ad grs. v) per capsule. One capsule should be taken after breakfast and dinner with a full glass of water. The patient is warned that the face and other parts of the body may become red and hot. He is told that this is a normal reaction in many individuals, and that it passes off in from fifteen to twenty minutes.

Many of these cases of nerve and conduction deafness show a low basal metabolic rate; hence, when there is evidence of thyroid, pituitary, or sex gland deficiencies, these substances should be supplied. Also, the hemoglobin and blood cells may be out of line, and many women give a history of menstrual difficulties, etc. Hence, it is quite obvious that in a study of an individual suffering from any type of deafness, a most careful physical examination, dietary study, several audiometric checks, examination of the nose, throat and ears, are necessary before any attempt is made to prescribe for the individual.

A study of creatinin and creatin in the urine of two hundred of these patients shows 50 per cent are out of line. This study was made by Professor H. H. Beard, Biochemist of the University of Louisiana. Beard thinks these findings point to

a muscular dystrophy, and the obvious muscles involved are the tensor tympani and stapedius. Studies are to be made of some of these individuals to see if there are other muscular dystrophies present elsewhere in the body.

The use of glycine or prostigmin has improved the hearing in some cases, and thus appears to support Beard's theory.

CONDUCTION DEAFNESS (OTOSCLEROSIS)

A positive differential diagnosis of otosclerosis, adhesive deafness and atrophy of the muscles in the middle ear (tensor tympani, stapedius) is not possible during life, and cannot be proved until histological studies are made after the death of the individual. Some authors claim that 70 per cent of deaf people have otosclerosis; others not over 6 per cent. Others will not make a diagnosis unless the deafness is found in at least three generations in a family. Indeed, opinions are changing regarding the subject of heredity and are now thought to be influenced more by environmental factors.

Three years ago a questionnaire was sent to the members of the San Francisco League of the Hard of Hearing, reading as follows: (1) What was the condition of your teeth in childhood, adolescence, and the early adult period? (2) Were they chalky, and did they break down easily? (3) Were many filled? (4) Were you a breast-fed child or a bottle baby? (5) Were you fed on condensed milk? (6) How much milk was used during childhood and adolescence? (7) How many eggs per week did you eat? (8) How much cereal, and what kinds? (9) Were you given cod-liver oil in childhood, and how long was its use continued? (10) Did you eat a lot of bread and candy? (11) How old were you when you began to use orange juice, and was it taken regularly? (12) What diagnosis has been made of your hearing defect?

In over 50 per cent the answers showed bad teeth, an excessive use of white flour products, and candy; few vegetables or salads; and few, if any, citrus fruits. A similar questionnaire was sent to several otosclerosis patients whose genetic history was studied by Professor Davenport several years ago. Their histories tallied with those studied by myself. The children of two families studied by Davenport who had been fed from birth on a well-balanced diet, repeatedly tested for hearing, showed no drop in the hearing in the region of the voice (250 to 4096 cycles). This is suggestive that environmental factors are perhaps more important than hereditary factors.

A similar dietary history has been obtained from fully two hundred cases studied in recent months. Approximately 100 per cent of these cases showed, in the twenty-four-hour urine specimen, a low vitamin B₁ output, and 50 per cent have an increase in porphyrin.

PREVIOUS STUDIES

Considerable study through the years⁶ has been directed to bone pathology, circulatory and inflammatory factors, including the vasomotor mechanisms, endocrinology, metabolism, and psychology. There is no evidence that the study of all these

TABLE 1.—Percentage of Patients Whose Hearing Improved, Became Worse, or Remained the Same During Treatment and Observation (Nash)
As Indicated by Audiometer

Type	Better	Worse	Same
Chronic catarrhal otitis media	52%	44%	4%
Chronic purulent otitis media	47	47	6
Nerve deafness	25	74	1
Otosclerosis	57	42	1

factors was followed through in a single case or in groups.

A recent paper by Nash,⁷ which was read before the American Otological Society in 1937, states in the conclusions: "Although the study indicates a result in the treatment of chronic progressive deafness that is not gratifying, it represents the best that we are able to accomplish and is our response to the demand of the patient, not hopelessly deafened, to exert some effort in his behalf.

"The present conservative treatment of chronic progressive deafness is unsatisfactory and inefficient."

In 1935, the following studies were instituted by R. K. Main and several others, at the Harriman Laboratories at the Southern Pacific General Hospital: vitamin C (blood), cholesterol, total serum protein, serum albumin, serum globulin, A. G. ratio, serum calcium, diffusible calcium, C. P. ratio, inorganic serum phosphate, R. B. C. magnesium, and phosphatase. Elsewhere (in my own office) the vitamin A (photometer) studies were conducted. The determinations of vitamin B₁ output and porphyrin were conducted by R. K. Main and Jesse L. Carr, and quite recently the creatinin and creatin studies were carried on in the Harriman Laboratories. X-ray studies of the petrous bones, jaws, and pelvis have been made to determine whether increased calcium deposits were present.

These studies, in addition to blood counts, basal metabolic rates, blood pressure determinations, endocrine studies, and dietary histories, have furnished us with fairly complete data as to all the factors now known to be involved in this subject of conduction and nerve deafness.

ADHESIVE DEAFNESS

The outstanding factor in this type of deafness appears to be an unresorbed mesenchyme, due to

the lack of the intracellular cementum (cevitamic acid). Guggenheim particularly has called attention to its importance, which seems to be in many instances the basis for adhesive bands. The lack of the intracellular cementum plays an important part in nasal allergy, and undoubtedly explains some of the cases of serous or mucous catarrh of the middle ear not associated with definite infections of the lymphoid tissue in the nasopharynx, or infections from the sinuses.

CASE REPORTS

Case report summaries are not printed, owing to lack of space.

COMMENT

Sufficient time has not yet passed to determine whether our results are better than those reported by Nash, whose cases were followed through a five-year period. He lists "Conservative Treatment of Deafness—Correction of Infective Processes" and attempts to restore normalcy to the conductive mechanism in the middle ear by various measures (see original article), including inflation and bougieing of the eustachian tube; oto-massage; correcting nasopharyngeal pathology; removal of tonsils and adenoids; thermal procedures, *i. e.*, infra-red, ultra-violet, diathermy, short-wave therapy; endocrine therapy; vitamins B and C.

It is my belief that many things commented on by him, such as enlarged tonsils, deviated septum, cold-catching tendency, and sinus infections are definitely related to faulty diets plus other metabolic disturbances. Most of the surgery of today is useless, so far as improvement in hearing is concerned, especially in patients over the age of fifteen, and yet some of it is necessary, as badly infected tonsils, for instance, the removal of which may improve the general health. Badly deviated septa interfere with proper ventilation of the nose and when corrected seem to lessen nasal infections in many instances.

Recently I prepared a paper for the mid-winter clinical course⁸ held in Los Angeles (January, 1938), in which I tried to show that the subject of chronic progressive deafness was intimately related to disorders of nutrition and not due to any single factor; that each case should be studied by itself; and that the mineral salts, vitamins, amino-acids, and ductless glands, the metabolic rate, and dietary faults should be given full consideration before any attempt was made to treat the individual. Other environmental factors should not be overlooked.

TABLE 2.—Amount of Gain or Loss in Hearing Sustained During Treatment or Observation (Nash)

Type	Hearing Improved		Hearing Became Worse	
	Average Gain	Greatest Gain	Average Loss	Greatest Loss
Chronic catarrhal otitis media	7.3%	26%	9.4%	39%
Chronic purulent otitis media	13.0	28	9.9	24
Nerve deafness	8.0	10	14.0	40
Otosclerosis	9.8	16	13.0	30

Dr. Horace Newhart of Minneapolis, well known for his great interest in defective hearing in children, says in a recent article: "Malnutrition, a deficient diet, endocrine imbalance, allergy, anemia, and various systemic diseases are all recognized causes of diminished hearing acuity."

CONCLUSIONS

I believe the time to begin treatment of a prospective otosclerotic is before birth! This should also apply to adhesive deafness as a preventive measure. The mother should have an optimum diet during her entire pregnancy, and the child when born should be treated the same way. The dietary correction should be carried through childhood and adolescence. This is the only way the deafness can be obviated. Therefore, the burden lies on the parent, and it is the duty of the internist, obstetrician, and pediatrician to see that this is carried out.

Much can be accomplished in the early stages of conduction deafness before puberty. Something may be done between the ages of twenty and thirty, and it is possible after that period to stay the progress of the disease by correcting the dietary faults and whatever under- or overfunctions appear in the sex glands as well as the other glands.

The important factors in diet should be: One egg daily; at least one pint of milk daily; one leafy salad daily; orange, grapefruit, or lemon daily.

Make up the balance of your diet from the following menus taken from "Notes on Vitamins and Diets," by Dr. Daniel Quigley:

SUGGESTED MENUS

Composed of Foods Having Relatively High Vitamin Content

Breakfast

Orange, tomato, or grapefruit juice; melons, strawberries, rhubarb, or other raw fresh fruit.
Whole grain breakfast foods; oatmeal.
Eggs (any style); bacon, ham; pancakes made from whole wheat flour.
Whole wheat or whole rye bread or toast, dry or with butter or honey.
Milk, or coffee with cream.

Lunch or Dinner

Tomato or vegetable soup.
Oysters or fish (preferably not salted), fresh or canned.
Meats, especially liver, heart, sweetbreads, kidneys, brains; fowl or game.
Tomatoes (any style), asparagus, parsnips, peas, carrots, beans, cabbage (preferably raw), mushrooms, onions, lettuce, eggplant, brown rice, wild rice, corn, cucumber, pickles and olives, parsley, watercress, broccoli, cauliflower, potatoes, spinach, celery.
Salads with French or mayonnaise dressing.
Whole wheat muffins or biscuits; whole grain bread with butter.
Tea, milk, cocoa, fruit juices, beer.
Ice cream or fruit sherbet; apples, alligator pears, apricots, pears, figs, pineapple, peaches, strawberries, nuts.

The above dietary list is offered as a valuable guide, and at the outset it is suggested that the products of white flour and highly treated cereal foods and sugar be almost entirely eliminated from the diet.

It is also suggested that people living in districts where vegetables, salads, etc., are hard to obtain during winter months should obtain preparations

of cod-liver oil, vitamin B (found in yeast, wheat germ, whole cereal, grain, etc.), and vitamin C (found in oranges, lemons, and grapefruit).

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CHRONIC SALPINGITIS: HYSTERO-SALPINGECTOMY IN ITS OPERATIVE TREATMENT*

By JOHN C. McDERMOTT, M.D.
Los Angeles

SALPINGITIS, acute and chronic, is perhaps the most frequently encountered gynecological problem. In its treatment several points have become quite generally accepted, while on other points there remains a considerable divergence of opinion. We know that conservative treatment such as rest and the various forms of heat therapy in the acute and subacute stages results in a high percentage of clinical cures. We know also that recurrences of pelvic inflammation may be diminished by clearing up foci such as the cervical, Bartholin's, or Skene's glands, and by avoiding reinfection from an outside source. Furthermore it is recognized that operative procedures show markedly lower mortalities if they are delayed for a considerable period of time after the inflammation has subsided.

TYPES OF OPERATIVE PROCEDURES

It is on the type of operative procedure that we find a considerable difference of opinion. In general there exist two schools of thought, the one which advocates extreme conservatism, and the other which teaches that, in operating for salpingitis, a bilateral salpingectomy and hysterectomy should be performed. Seeking the answer to this question is the purpose of this paper.

On looking up the question in various gynecological textbooks we find no definite statement. Conservatism in general is urged, but the greater per cent of clinical cures with radical surgery is mentioned.

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Read before the Section on Obstetrics and Gynecology of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1-4, 1939.

To answer the question of whether salpingectomy alone or with a hysterectomy should be performed, the end results of a series in which salpingectomy alone was done should be studied. There are many difficulties in the way of such a study. It would require follow-up over many years, a task which the instability and uncooperativeness of patients make almost impossible.

APPROACH TO THE PROBLEM

We are forced then to approach the problem indirectly by gathering our data from those who have had salpingectomies and subsequently came to our clinic for further treatment. We have no way of knowing what per cent of salpingectomies they represent, particularly since this operation without hysterectomy is rarely done at our clinic. The data herewith presented were obtained from a study of the hysterectomies at the Los Angeles General Hospital for the year 1936-37.

ANALYSIS OF THE CLINICAL MATERIAL

Out of 839 hysterectomies, 339 were hysterosalpingectomies for pelvic inflammatory disease. Fibroids were second with 290, and third came 60 cases that had had bilateral salpingectomy for salpingitis and later required hysterectomy for one reason or another. In addition, there were 35 cases in which a unilateral salpingectomy had been done previously, presumably for salpingitis, and a chronic salpingitis of the other tube was present at the time of hysterectomy. It was impossible to determine the indication for the initial salpingectomy with sufficient accuracy, however, to use in this study. In only three of these the original operation had been done at the County Hospital.

SUBGROUP OF SIXTY CASES

A study of the 60 cases requiring hysterectomy subsequent to bilateral salpingectomy for salpingitis showed the following:

1. The presenting complaint was:

Menorrhagia and metrorrhagia.....	20 cases
Abnormal bleeding with pain.....	28 cases
Abnormal bleeding with tumor.....	1 case
Pain (lower abdominal, dysmenorrhea, backache) without abnormal bleeding.....	11 cases
2. Time elapsed between salpingectomy and appearance of symptoms which necessitated hysterectomy:

Less than 1 year.....	29 cases
1 to 5 years.....	9 cases
5 to 10 years.....	16 cases
10 to 15 years.....	6 cases
3. Time elapsed between salpingectomy and hysterectomy:

Less than 1 year.....	3 cases
1 to 5 years.....	20 cases
5 to 10 years.....	17 cases
10 to 15 years.....	11 cases
Over 15 years.....	9 cases
4. The pathology found at the time of hysterectomy:

Adhesions.....	10 cases
Adhesions with cystic ovaries.....	17 cases
Adhesions with fibroids.....	10 cases
Adhesions with fibroids and cystic ovaries.....	5 cases
Fibroids without adhesions.....	4 cases
Cystic ovaries without other lesions.....	4 cases
Simple ovarian cysts.....	2 cases
No apparent lesion of ovaries and uterus.....	2 cases

We see that adhesions were present in 42 patients, cystic ovaries in 22, fibroids in 19.

In these 60 patients we see sixty attempts at conservation that went wrong. Each one was subjected to a second major operation unquestionably more difficult than the first because of the post-operative adhesions. With the fibroids it is obvious that a hysterectomy at the first operation would have avoided more trouble. In those cases of cystic ovaries the difficulties arose only in so far as abnormal uterine bleeding was produced and, therefore, hysterectomy at the time of the first operation would have avoided subsequent trouble. As far as the adhesions are concerned, it is quite probable that subtotal hysterectomy, by removing the raw areas of the uterine surface (which are such a source of adhesions) would have prevented their development to such an extent as found here. It is of interest to point out here that all ovarian tissue had to be removed in 24 of the 60 cases. The necessity for this was due not to the cystic state of the ovaries but to the adhesions of the ovaries to the uterus, which would have been avoided had the uterus been removed with the earlier surgery.

ARGUMENTS OF PROPONENTS OF CONSERVATISM

Let us consider now the arguments offered by the proponents of conservatism:

1. *Preservation of child-bearing function.*

This point, of course, is pertinent only where plastic operations on the tube or unilateral salpingectomy are performed. My one experience along this line ended with a flare-up in the remaining tube six months postoperative, and a second operation two years after the unilateral salpingectomy. Though I feel the chances of success are slight, such procedures are undoubtedly justified if the patient realizes the risks and still wishes to assume them.

2. *The physiological value of the uterus.*

Many persons advocate preservation of the uterus for the psychological value of menstruation. It has been my experience that if the patient is reasonably intelligent, and the doctor will take the trouble to explain a little of the physiology of menstruation, the patient will choose to have the uterus out. One need only inquire around a little to find how our modern women dislike menstruation.

Certain persons have advanced the idea that the uterus is an endocrin organ. No proof of this has been presented, and in a recent article Novak states that the only known physiological value of the uterus is for the purpose of child-bearing.

Should the patient desire continuance of menstruation, a high subtotal hysterectomy would permit it, while greatly diminishing the chances of later surgery.

3. *The technical difficulties of hysterectomy.*

This is refuted by simply examining the facts. If the corpus is relatively free so that one might consider leaving it, removal is simple. Where there are dense adhesions, it is technically difficult, but here even the conservationists would not advocate leaving it.

SUMMARY

The speaker would like to point out that he has presented 60 cases coming to the Los Angeles County Hospital within one year, all of whom had had bilateral salpingectomies for salpingitis and later had to have hysterectomies. Unquestionably, for every one of these, there are several who suffer from symptoms due to the "left-over uterus," but who are so discouraged by the poor results of their one operation that they refuse a second; or whose symptoms are not quite sufficient to justify another major procedure.

To digress for a moment on the subject of conservatism: it is an unfortunate word. Confusion is created by using it in relation to an organ or group of organs, and also in relation to the patient as a whole. To conserve an organ may or may not be conservative as far as the welfare of the patient is concerned. The result has been that incomplete surgery is often given standing by being labeled conservative.

This is a problem affecting the welfare of a great number of patients. We should make an effort to follow up these cases over a long period of time and examine the results critically so that we may eventually decide upon a really conservative surgical procedure.

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LABORATORY METHODS FOR DIFFERENTIATION OF VARIOUS NEUROTROPIC VIRUSES*

By BEATRICE F. HOWITT, M. A.,
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DURING the past few years it has become apparent that more detailed attention should be given to the differentiation of the several types of neurotropic virus diseases affecting man. Formerly the etiologic agents were known for only poliomyelitis and rabies, while now a number of viruses have been isolated that are recognized as affecting the central nervous system, especially causing the encephalitic or encephalomyelitic form of disease.

So far no active agent has as yet been recovered from the von Economo type of encephalitis, which has been known for many years as a clinical entity and designated as Type A, in distinction to another—Type B—variety of encephalitis occurring in the summer, and distinguishable both clinically and epidemiologically. While human cases of acute encephalitis have been reported for many years, yet it is mainly within the past decade that the active agents have been isolated from an increasing number of these neurotropic diseases. However, one must also take into consideration that, besides these acute encephalitic types of known viral nature, there is another group showing encephalitic symptoms subsequent to certain infectious diseases such as measles, mumps, or the like. Their etiology is as yet undetermined.

* From the George Williams Hooper Foundation, Medical Center, University of California, San Francisco. Aided by grants from the National Infantile Paralysis Foundation.

TYPES OF NEUROTROPIC VIRUSES

Because of the recent advances in virus isolation, one can now distinguish at least five or six different types of neurotropic viruses which can be immunologically and serologically differentiated. Those affecting man are known, respectively, as the viruses of poliomyelitis, St. Louis and Japanese B encephalitis, lymphocytic choriomeningitis and of equine encephalomyelitis, both eastern and western strains. The British have also identified a pseudolymphocytic choriomeningitis. And one may add the rabies virus.

How are they to be distinguished when, in many instances, the early symptoms are very similar, especially in a subclinical or very light attack? It is probably the function of the laboratory to aid in the differentiation. Not all laboratories, however, are equipped to make the differential tests, since it takes many animals of various kinds and specific immune serums.

DIFFERENTIATION OF NEUROTROPIC VIRUSES

In general, one may endeavor to obtain material and to distinguish the neurotropic viruses by the following methods:

I. POSTMORTEM MATERIAL.

If an autopsy has been made, then fresh brain, brain-stem, and cervical cord should be taken out (as free from bacteria as possible) and kept in a sterile container on ice until delivery to the laboratory. If the latter is at a distance, the material should be placed in a sterile, dry fruit-jar with a well-fitting top, and then put into a container with either dry ice or real ice and sent by express as soon as possible. Bacterial contamination may tend to destroy any virus present, especially if the growth produces much acid.

At the laboratory, suspensions of the material should be made in some sterile diluting fluid such as saline, Ringer's or Tyrode's solutions, and then inoculated into suitable animals intracerebrally, or in a combination with intraperitoneal and intranasal injections. Histologic sections should also be made at the same time. In addition, one should take into consideration the possibility of tubercular infection, of infection with such fungi as *torula* or *coccidioides*, which may cause occasional confusion. The former may be differentiated by recovery of acid-fast rods from both human and animal tissues, while the other organisms may be found in both stained sections and in cultures of the brain, as well as after animal inoculation. The *torula* organism may be isolated on Sabouraud's medium. Spinal fluid from the patient should also be cultured during the course of the disease.

The procedure used for the respective viruses may be as follows:

1. *Rabies*.—Material from the hippocampus should be examined for Negri bodies, preferably by sections, and inoculations of a 10 per cent suspension should also be made into mice as well.

2. *Poliomyelitis*.—Monkeys should be inoculated with rather large amounts of cord and brain-stem suspensions.

3. *Encephalitic Types of Cases*.—Mice and guinea pigs, as well as monkeys, should be included for the inoculations.

(a) *Poliomyelitis*.—Monkeys, and not white mice, will develop the disease; showing irritability, fever, nervousness, followed by a typical flaccid paralysis of one or more extremities, and often complete prostration and death. There is no demonstrable virus to be found in the blood or spinal fluid.

(b) *St. Louis Encephalitis*.—The mice, and not the guinea pigs, will be affected after four to five days' incubation, while the monkeys may or may not become ill, without a flaccid paralysis. They may show merely a temperature, irritability, nervousness, followed by recovery. There is no virus in the blood or spinal fluid.

(c) *Japanese B. Encephalitis*.—Monkeys as well as mice, are very susceptible, the infection in the former running a very severe course and ending fatally. Virus may be demonstrated in the blood and spinal fluid.

(d) *Equine Encephalomyelitis*.—Rats, rabbits, and monkeys are all susceptible, with guinea pigs and mice as the animals of choice. Since this virus may be differentiated into several types, one cannot always rely on the clinical picture in the animals, although there are certain distinguishing criteria.

(1) The western form has a four- to five-day incubation in guinea pigs, with a rise in temperature on the second day to 40.8 or 41.0 degrees centigrade and a gradual decline when symptoms appear.

(2) The eastern form shows a two-day incubation with abrupt rise in temperature to 41.0 degrees centigrade in twenty-four hours, and a rapid decline followed by death. The animal also may show a spastic tremor with retraction of the forelegs and extension of the hindlegs. Virus may be recovered from the blood in both of these types during the febrile period, and also from the spinal fluid of monkeys.

(3) One of the Russian types (Moscow 2) is also a four-day virus, but the temperature does not rise much above 40.0 degrees centigrade, and usually on the third day. There is no demonstrable virus in either the blood or spinal fluid.

VIRUS ISOLATION CRITERIA

In case a virus should be isolated from the animals, the following criteria may be used for further identification:

1. One should note the appearance and behavior of the animals, the temperature curve, and incubation period.

2. Cross immunity tests should be used in hyper-immune animals.

3. Neutralization tests should be made against known immune serums.

(This is probably the most dependable method of identification, because the antibodies for each neurotropic type are apparently specific, not only for each separate strain but for the types within a group.)

4. Complement-fixation tests may also be used for several of the viruses to supplement the neutralizations, except in the case of poliomyelitis.

Before attempting any of these differential methods, however, repeated animal passage of the virus for stabilization should be made, and then a determination of the titer and the strength of dilution to be used. This is necessary to avoid too concentrated a virus for any immune serum that might have weak antibodies. When all these data are obtained from a newly isolated virus, then one may be able to determine if it is a known type that is present or a new one has been found.

II. MATERIAL FROM CLINICAL CASES.

If a patient is suspected of having a neurotropic disease, the following methods may be employed to help differentiate the type. Blood and spinal fluid should be obtained at entry to the hospital, and both should be inoculated into suitable animals to determine the presence of a virus according to the criteria previously described. Repeated testing of such material might be advisable during the acute febrile stages. About 10 to 15 cubic centimeters of blood should be taken aseptically with a dry sterile syringe and put into a dry sterile tube or vaccine bottle having a sterile stopper. The serum may then be removed aseptically from the clot.

(a) No virus will be found in the blood or spinal fluid in the case of the St. Louis encephalitis or poliomyelitis.

(b) Virus may be present during the acute, febrile period in both blood and spinal fluid for the equine strains, and for lymphocytic choriomeningitis. It may also be recovered at later periods for the latter virus.

(c) Nasopharyngeal washings and fecal specimens from cases of poliomyelitis may or may not contain virus when inoculated into monkeys.

NEUTRALIZATION TESTS

Neutralization tests should be done on the blood serum during the early stages of the disease, then again after recovery of the patient, and probably again in about two months from the onset. Although the antibodies for the St. Louis and the equine types are developed rather rapidly, those for the virus of lymphocytic choriomeningitis may not show until after several weeks or even months. If the test is negative or weakly positive at first, and antibodies are found later, then one may be more certain of the etiologic agent.

The neutralization or protection tests, as usually performed, consist in mixing equal parts of the unknown serum with different dilutions of a known stock virus whose titer has been previously determined. The mixtures are kept usually in the icebox for a certain number of hours before inoculating the test animals intracerebrally. The latter are then observed during the incubation period, which may differ for each virus used. The temperatures are taken on the larger animals in order to observe the course of the disease. If the serum to be tested does not contain protective antibodies, all animals will become sick or die within the re-

quired incubation period for each strain of virus, and the results are called negative. If protective substances are present, the animals will remain well, although they should be observed over a longer period of time to be certain that there is no delayed action of partially neutralized virus. If all animals survive for all dilutions used, the test is called positive; but if they succumb to a strong dilution of the virus and survive a weaker, the test may be called weakly positive.

Because of the difference in incubation period for the different viruses and of having to observe the animals for a certain length of time, results need not be expected for at least several weeks. This is especially true if a serum is being tested against several different viruses.

While the neutralization test is of specific value in determining the type of virus one has isolated from a tissue, and is of importance in finding the presence or absence of antibodies in a given serum, yet in the latter instance the real significance of a positive test for a particular virus may be difficult to decide if one finds the same serum showing protective substances for more than one type of virus. The past history of the patient should then be well investigated as to any possible previous infection.

The presence of neutralizing antibodies for poliomyelitis in a human serum has little diagnostic significance, since a high percentage of normal individuals may possess these substances. Their presence for the St. Louis virus in an endemic area may not necessarily indicate that it is the etiologic agent, unless the serum was negative at first, becoming positive later. At present, in California at least, the equine virus has not become sufficiently disseminated among the human population, so that one may have more reliance on a positive test against this strain. For an absolute diagnosis, however, the real criterion would be the recovery of a particular virus from some tissue whenever possible, thus indicating the desirability of securing material at autopsy.

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TINEA CAPITIS ON THE PACIFIC COAST*

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TWENTY-NINE years ago Sabouraud¹ first described the spontaneous cure of tinea capitis. He also noted that in all these cases the causative organism was pathogenic to certain animals. It is only recently, however, that this fact has been reemphasized by Lewis²⁻⁵ and his coworkers. He stressed the ease with which cases of tinea capitis due to the animal type of ringworm are cured, and that epilation with thallium acetate or x-ray is unnecessary. In ten consecutive cases due to *Microsporon lanosum*, in which daily shampoo and local

measures only were used, he found that the patients were free from the disease in an average period of seven weeks and, interestingly enough, the local therapy consisted of petrolatum colored with bolus rubra. In cases where strong fungicidal medication was employed the time for cure was not shortened. In contrast, however, infection with the human type of ringworm almost always requires total epilation, and local therapy despite its vigor is not of great value. This topic has frequently been a subject of controversy among the dermatologists of the East and West coasts; the former expressing amazement as to the ease with which the westerners claim to cure their patients, while the latter feel that the eastern dermatologists frequently subject the patients to useless epilation.

Kingery⁶ reported the cure of tinea capitis in the vicinity of Portland, Oregon, by topical application of 0.5 per cent thymol and 1 per cent oil of cinnamon. Loomis⁷ of Cleveland, Ohio, repeated this form of therapy most vigorously, but with poor results. He concluded that the medication was of little value, and his patients eventually required epilation of the scalp for a cure. These apparently conflicting results are not surprising in view of our present knowledge. Although the type of organism was not identified in either of these reports, it is most likely that the cases successfully treated with the local application of thymol and oil of cinnamon were due to *Microsporon lanosum*, while the more resistant cases requiring epilation were due to *Microsporon audouinii*.

The purpose of this report is to show that tinea capitis in the vicinity of San Francisco Bay area, and probably on the Pacific Coast, is due almost always to *Microsporon lanosum*, the animal type of ringworm, and is readily amenable to a simple local therapy without resort to epilation.

CULTURES AND IDENTIFICATION OF ORGANISM†

A few years ago,^{8,9} and again recently,¹⁰ it was shown that even a slight variation in the media, used for culture of fungi, affects the morphologic characteristics of the organisms; and even in primary cultures¹¹ there may be variations in the morphology. It has also been shown that multiple hanging drop preparations¹² performed with the same organism at the same time may reveal lack of uniformity of growth. These facts, combined with the tendency of cultures to undergo sectoring and pleomorphic changes,^{13,14} make it most difficult to accept a classification based on purely morphological grounds. At the present time, however, despite its numerous shortcomings, this is practically the only method available for the classification¹⁵ and identification of the various types of fungi.

CLINICAL MATERIAL FOR THE STUDY

A total of fifty-eight cases of tinea capitis were studied. Forty-eight cultures were found to be *Microsporon lanosum*, one *Achorion schoenleini*, two were not identified, and seven cultures were

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† Read before the Section on Dermatology and Syphilology of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1-4, 1939.

† Sabouraud's media used was made with bacto peptone 1 per cent, agar 1.5 per cent, difco maltose 4 per cent.

unsatisfactory (no growth or overgrown by contaminants). Considering these facts it may be that some cases due to *Microsporon audouini* were not discovered in this group. Some variants or other species of animal ringworm may have been included. True favus infection (due to *Achorion schoenleini*) on the Pacific Coast is extremely rare. The culture noted here has been previously reported.¹⁸

No cases in the series were found to be resistant to local therapy. Many cases of tinea capitis on the Pacific Coast clear despite little or desultory treatment. In this series of cases, one-half strength Whitfield's ointment, various percentages of sulphur ointment, ammoniated mercury, iodine in goose grease, unguentum quinolor compound and boric acid ointment, were used with no apparent difference in the results. No cases in this series required epilation for cure.

AN OUTLINE OF TREATMENT FOR TINEA CAPITIS DUE TO MICROSPORON LANOSUM

1. Clip hair as short as possible, and repeat as often as needed until cured. This facilitates application of local therapy and exposes small infected foci which may be overlooked.

2. Shampoo scalp daily. This helps remove loose infected hairs.

3. Apply a fungicide to scalp twice daily. Half-strength Whitfield's ointment is suggested.

4. Epilate infected patches with epilating forceps or adhesive tape. This is most important, as it removes the loose infected hairs. (Adhesive tape is simple to use, quicker and more effective than manual epilation with the forceps.)

5. The child should wear a paper cap which can be burned or one of cloth that can be boiled. These caps should be changed daily.

6. With kerion formation, nonspecific foreign protein therapy intramuscularly should be employed, as well as boric acid or potassium permanganate compresses.

7. When there is no evidence of clinical activity as manifested by absence of scaling, pustules or short stumps of broken-off hairs, and two weekly successive microscopic examinations (and, if possible, cultures) are negative, the child can be considered cured.

CONCLUSIONS

1. Tinea capitis in the vicinity of the San Francisco Bay area in this series of cases was caused by *Microsporon lanosum*, the animal type of ringworm.

2. Tinea capitis due to *Microsporon lanosum* is curable by local measures without the use of x-ray or thallium acetate epilation.

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ANENT PRONUNCIATION OF MEDICAL WORDS

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THIS concerns not what is said, but how it is said. The former certainly is the more important; but the latter, if improperly executed, distracts one's attention—as an otherwise perfect piano rendition may be marred by one discordant note.

In attending medical meetings the writer has become impressed with what appears to be a surprising disregard by the average doctor for the correct pronunciation of commonly used medical and scientific words. A presentation may be so interesting and illuminating—the listener so absorbed by what he hears—that he never once is aware he listens to "words." Instead, pictures and thoughts reach his sensorium, and he is attentive and comprehending. But let the speaker say *ecse'ma* instead of *eczema*, and immediately the listener's attention is diverted. So far as we are concerned, fully two sentences must pass unheard, while we wonder why the gentleman didn't bother to learn the correct pronunciation for the word. Moreover, the prestige of the speaker as an authority is, from that point on, in jeopardy. It seems foolish and quite unnecessary to lose one's audience for a reason so easily avoidable.

CAUSES OF MISPRONUNCIATION

Several explanations suggest themselves as possible causes of mispronunciation: indifference, ignorance, and common usage. The last mentioned is probably the most important; and, when this is the cause, even a visit to the dictionary may be of but little help in giving an answer. One may find the

correct form together with two or three others dictated by common usage alone. Consider, for example, the word "gynecology." One must choose from among three or four pronunciations, all apparently acceptable. Such disorder no doubt contributes to mispronunciation.

In the matter of indifference, incorrect pronunciation frequently arises from slovenly enunciation. For example, speakers often say *lab'-ra-to-ry* with four syllables, while the word has five and should be pronounced *lab'-o-ra-to-ry*.

The term "correct pronunciation" is not entirely self-explanatory, and doubtless many who use the expression would be unable clearly to define it. Probably it would be safe to say, however, that any given word is pronounced correctly if used in one particular form by a sufficient number of cultivated speakers. Under such conditions an acceptable standard of correct pronunciation may be said to be that which is in common use by cultured and educated people to whom the language is vernacular.

In scientific and medical speech, as in everyday English, styles of pronunciation change. Some members of the old school still say *gooms* instead of *gums* and *wownd* instead of *wound*. Others still use the suffix *-etis* rather than *-itis*: *appendicitis*, *tonsill-etis*, *ar-thretis*, and so on. At one time such pronunciations were acceptable; now they are simply conspicuous.

In attempting to find an authoritative source of information on correct pronunciation it soon became evident that, for scientific words, there is no large exhaustive work such as there is for ordinary English. Therefore, for the purposes of this discussion, the standard medical dictionaries are presumed to be authorities, together with the standard general dictionaries in some instances. For the most part these are in close agreement with each other. As a rule where several pronunciations are in common use, each is given, and if one is more desirable it is so stated.

GROUP DIVISION OF MISPRONOUNCED WORDS

Words commonly mispronounced may be divided, for convenience, into two groups; those over which there is general agreement among authorities on one pronunciation, and those which have two or more acceptable forms, one or another of which might be stated to be preferable.

In the first group we find such words as the following. How would you pronounce them?

Adult	Ramus	Maxilla
Research	Nomenclature	Axilla
Cocci	Trichomonas	Protein
Chiropodist	Duodenum	Discharge
Abdomen	Ouabain	Epiphyseal
Autopsy	Endocrine	

All of us have heard one or more of these words mispronounced. Indeed, it is likely that not one physician in a hundred pronounces all of them correctly. Yet the dictionaries agree on but one correct form:

a-dult'
re-search'
cok'-si (not cok'-ki)
ki-ropodist (not sheer-opodist)
abdo'-men (not ab'-domen)

au'-topsy (the first syllable is definitely accented)
ray'-mus (the *a* is long as in *date*)
no'-men-clature (not nomen'-clature)
trikom'-onas (the accent is on the second syllable—believe it or not)
duode'-num (not duod'-enum)
wah'-bah-in (three syllables, not two)
en'-doctrine (not en'-doctrene)
maxil'-la (not max'-illa)
axil'-la (not ax'-illa)
pro'-te-in (three syllables, not two)
dis-charge' (not dis'-charge)
epifiz'-eal (not epifi-se'-al)

SOME MEDICAL WORDS FREQUENTLY USED

There is an interesting group of words that we use often in our daily conversation which is made up principally of proper names. Included in this group are Wassermann, Weil, Widal, Wertheim, and so on. The question arises as to whether these names should be pronounced as the Germans pronounce them, or if they may be properly regarded as having become Anglicized. Should one say *Wassermann* or *Vahsermahn*, *Wile* or *Vile*, *Widal* or *Vedal*, *Wertheim* or *Vertheim*? It is seldom one hears a doctor use the German form and yet, somehow, it seems proper to do so. No musician in speaking of Wagner would think of saying anything save *Vahgner*. Why shouldn't we do the same with the others? Yet, if we are to be guided by common usage we should drop the German form.

A group of related words commonly mispronounced is that which identifies the barbituric acid derivatives, including the many proprietaries which belong to that family of drugs: barbital, phenobarbital, nembutal, amytal, seconal, etc. It is in the last syllable that mispronunciations occur. As in the case of Widal, the final *al* has the same sound as the first syllable in *tallow*, not as it sounds in the word *tall*. But here again we are criticizing widespread usage. In fact, correctness in the use of these words would likely disconcert a listener for the reason that, to the majority of an audience, the words apparently would be mispronounced; the bizarre is arresting whether it be correct or incorrect.

ALTERNATIVE PRONUNCIATIONS

There are a few commonly used words for which the dictionaries give more than one acceptable form of pronunciation. Such a word is "gynecology." Stedman, in his 1928 edition, pronounced it *ji-*, with the *i* long as in *pine*, while the present 1939 edition changes to a short *i*, as in *pin*. Dorland conforms to the latter, while both agree on the *j* sound rather than a hard *g*. Webster allows for both the long and short *i* and adds a third, *gi-*, the hard *g* and long *i*. And finally, common usage provides for a fourth—the hard *g* and short *i*. Dr. Morris Fishbein, in his fascinating little book, "Doctors and Specialists," which so cleverly caricatures the medical profession, expresses it thusly: "The worst thing about the gynecologist is pronunciation. He is pronounced various, *gyne*, *ginni*, *jyni*, and *jinni*, any of which is right or wrong, depending on how he happens to feel that day." The writer is inclined to subscribe to this viewpoint.

"Iodine" is another word over which there is no complete agreement. The last syllable may be *-din*,

-dine, or -dene. Stedman gives the last two. Dorland gives but one form, -din. Webster accepts all three, but states that among chemists the preferred form is -dene.

Cadaver in both Stedman and Dorland has a short *a* in the second syllable, as in *have*, while Webster gives both the long and short *a* as correct. It has seemed to the writer that most doctors use the short *a*. Hygiene has more than one correct form. One authority says *hi'-gene* while another says *hi'-ge-ene* with three syllables. Calamine may be pronounced with either a long or a short *i*.

Stedman pronounces "respiratory" with the second syllable accented thus: *respī'-ratory*. Webster prefers this, but lists as a second choice, *res'-piratory*. Dorland gives but one form, *res'-piratory*. In this particular instance, it is strange that any pronunciation but that used by Stedman is accepted when one considers a similar word, *expiratory*, over which there is no disagreement by any dictionary. All agree the accent is on the second syllable. Both words have the same Latin derivation; so that if *expī'-ratory* is correct, then *respī'-ratory* also is correct.

OTHER EXAMPLES

Following are some additional words commonly mispronounced, but which have only one correct form:

	<i>Don't Say</i>	<i>Say</i>
angina	angi'-na	an'-gina
ascaris	ascar'-is	as'-caris
raphe	ra-phe'	ra'-phe
umbilicus	umbil'-icus	umbili'-cus
trichophyton	trichophy'-ton	tricoph'-yton
acetyl	ase'-tyl	as'-etyl
foramen	forah'-men (short <i>a</i>)	fora'-men (long <i>a</i>)
prosthesis	prosthe'-sis	pros'-thesis
tinnitus	tin'-itus	tini'-tus
eustachian	eustash'-ian	eustak'-ian
vitiligo	vitile'-go	vitili'-go (long <i>i</i>)
proteid	pro'-teid	pro'-te-id
rigor	rig'-or	ri'-gor (long <i>i</i>)
opisthotonos	opisthoton'-us	opisthot'-onos
cerebral	cere'-bral	cer'-ebral
caffeine	caf'-eine	ca'-fe-ene (three syllables)
paresis	pare'-sis	par'-esis
data	datta	da'-ta (long <i>a</i>)
status	stattus	sta'-tus (long <i>a</i>)

IN CONCLUSION

The writer feels that the correct pronunciation of words is not of so great importance if an incorrect form is in common use. For example: caffeine, trichomonas, the barbitals, and the German proper names. One is then apt to pay but little attention to it. But it is definitely disconcerting to the average listener when such words as eczema, abdomen, umbilicus, adult, research, and so on, are mispronounced.

The use of scientific words is essential in the discussion of medical subjects. Such words are our language, just as surely as are any other. We are among the most highly educated of all classes of men and women. My plea is that we take as much care with our medical language as we do with our ordinary speech—nay, a little more!

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FERMENTATION: A RETROSPECT

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WITHIN recent years great progress has been made in the field of enzyme chemistry. The chemical makeup of many of the oxidizing-reducing enzymic systems is now known. It has also been possible to crystallize many of those enzymes that are protein in nature, such as urease, pepsin, and chymo-trypsin. It is of interest to look back and to note what great strides have been made in the field of enzymes and how the views on enzymic reactions have changed.

The early views were that fermentation was a vitalistic process that could only occur in the presence of living matter. This idea was exploded by Buchner in 1897 when he isolated a product from yeast cells that fermented sugar to alcohol. However, as early as 1858 Traube advanced the view that a substance representing a product of its metabolism occurred in yeast cells that reacted with sugar to produce alcohol and carbon dioxide. What is most important was his idea that the reaction between the sugar and the substance present in yeast was one that was wholly independent of the parent cell. In its nature and relations this substance behaved similarly to that of a catalyst. While Traube did not live to witness Buchner's discovery, he nevertheless laid the foundation of our present ideas of enzymic reactions.

The modern work on enzymes is not only concerning itself with the isolation and identification of the enzymic systems, but is also attempting to elucidate the nature of the reactions between enzymes and substrates.

The vitalistic view of fermentation is set forth by William Salmon in Chapter X of the New London Dispensatory printed by Anton Saunders and issued on March 2, 1676. A copy of this has recently come into the possession of the University of California College of Pharmacy. This exposition is of sufficient interest to warrant reprinting here.

The New London Dispensatory by Salmon. Imprimatur, Anton Saunders. Mart. 2, 1676.

(COPY)

CHAP. X. OF FERMENTATION

1. Fermentation is a certain manifestation of Life, fitting it for a Resuscitation, and without which it would remain captivated within the Bonds or Chains of Death. Or, It is the breaking of the Bond of Corruption and Putrifaction by the power of Life, assisted by a Homogeneous Matter, or principle already freed.

2. It is caused from the Contest of two contrary Principles or Matters.

That is, which are opposite either in nature or form: so Life and Death, Purity and Impurity, Corruption and Incorruption, are opposite in nature, Acid, and Alkali, in form, &c. Here also it is observable, That that Principle or Matter which

is greater in power, retains the dominion: hence it is that some things cannot ferment without additions and helps, because the corruptible and dead part much exceeds the Life or pure part in power, &c. But in other things, where the Life and pure part transcends or exceeds the contrary, after a certain time, it creates a struggling as it were in the Womb, and by means of its own efficacy frees itself from that which subjugated it; the former is artificial, this natural.

3. *The Matter to be fermented, contains in it all the natural Principles.*

That is, Salt, Sulphur and Mercury, crude and indigested; if any one was wanting, the other could not be, because each two subsist, and are upheld by the third. As in an Equilateral Triangle, if you take away the Legs or Shanks constituting any Angle, you leave not two Angles behind, but only a right Line, which not only makes a nullity of the Triangle in general, but of the two remaining Angles in particular; there being nothing of a Figure left behind.

4. *Before Fermentation, the Matters being distilled can yield no Spirit, but a Flegm, and fetid Oil, according to the nature of the thing distilled.*

This is apparent from all sorts of Juices and Wort, of which Ale is made: the first, although the juice of the Grape, will yield nothing but Flegm, and a *Caput Mortuum*; the other a Flegm and stinking Oil: but let them be first fermented, then they will yield first their inflammable Spirit, and after that their Flegm. From hence appears, 1. the necessity of Fermentation; 2. that crude Juices, Herbs and Plants (Aromatics excepted, whose odour shews a previous natural Ferment) can lose none of their Spirits by boiling, whatever some have affirmed to the contrary. Yea, without it, it's impossible they should lose their spirituous and volatil parts in the least measure; since there is a power stronger than theirs, which holds them.

5. *After Fermentation, the matter is resolved or broken, made thin and ripe, whereby its Spirituous and Volatile parts are made subject to fly.*

The reason appears from the contrariety, or confusion of Parts fermentable, they being not yet brought under one power, or subjugated to life and purity; and being dissolved, 'tis apparent they are altered by force of a stronger faculty, and so brought and exalted to a more spirituous disposition, standing in a living active property.

6. *The Matter to be fermented, is chiefly all liquid substances.*

This is true, whether they be Acids, or Alkalies: Acids suffer fermentation by Alkalies, Alkalies by Acids; yet thicker Bodies are said to be fermented, as Syrups, Electuaries, Dough; but in these there can be no separation, by reason of the grossness of their bodies.

7. *The Matter fermenting, or causing the Ferment, is either the internal Spirit, or external Agent already freed, or both.*

Where the Spirit is powerful, and much transcends, it will cause a Fermentation alone, as in juice of Grapes: in other cases, where the Spirit is over-power'd, there is required an external Agent: as Leaven or Yest to Dough; Yest to

Juices, Wort, Infusions, Decoctions and Tinctures; Sugar, Honey and Alkalies, as Salt of Tartar, to Vinegar and other Acids; Vinegar, Cream of Tartar, Tartar Vitriolate, &c. to Alkalies; together with an external Heat. See Lib. 4. cap. 12. sect. 4. of this Dispensatory.

8. *The way and manner of the Fermentation, is done by mixing the Ferment with the Liquor, being a little warm, and in a wooden Vessel, shaking them well together, and then setting them in a warm place, or insulating them.*

9. *The End of Intention of Fermentation is twofold. 1. To take away the Crudity, and greatest part of the Terrestrial impurities. 2. In case of Distillation, that the Volatile and Spiritual Parts may be raised.*

10. *The Measure of the Fermentation, is from the Odour and Clearness of the Liquor fermenting.*

If it be too violent and long, it may cause a dissipation and evaporation of the Spirit (which ought to be kept) from whence follows sowness and deadness.

University of California College of Pharmacy,
Medical Center.

DIVERTICULITIS OF THE COLON*

By CLARENCE J. BERNE, M. D.

Los Angeles

AND

A. C. PATTISON, M. D.

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THE primary purpose of this report is to consider the acute major complications of diverticulosis of the colon. The cases studied are those seen in the last nine years at the Los Angeles County Hospital. This group constitutes only a small fraction of the total number of acute abdominal conditions; however, if one considers only patients over 40 years of age, it forms a much larger fraction of the total cases of acute abdominal disease. Further, if one considers the acute conditions involving only the lower half of the abdomen in persons over 40 years of age, acute diverticulitis is always a major possibility. The importance of the disease is even further increased by reason of its extreme gravity. Unfortunately its frequency has been underestimated. Moreover, the difficulty of making a precise diagnosis of an acute complication of diverticulosis is well known. Likewise treatment requires a difficult decision as to whether or not surgical intervention is indicated. If an operative procedure is to be carried out, it must be selected to conform to the stage of the disease. In a doubtful case, if the abdomen has been opened, a quick selection of the proper operative method is necessary and requires a familiarity with the results of various procedures. A lack of large series of cases of major complications of diverticulosis, and the need for analysis of the results in our own treatment of these cases, have furnished the incentive for this report.

* Read before the Section on General Surgery of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1-4, 1939.

TABLE 1.—Division of Cases of Diverticulosis

Total number of cases	273
Uncomplicated	159
Complicated	114
Total number of complications	128
Minor complications	64
Chronic diverticulitis	55
Hemorrhage	9
Major complications	64
Acute diverticulitis	54
Simple	12
Local abscess	16
Generalized peritonitis	26
Stricture	6
Fistula	4

For purposes of analysis it was necessary to design a classification of the secondary processes, *i. e.*, the complications developing upon a preëxisting diverticulosis. In order to more easily remember the complications of diverticulosis, it is valuable to point out the analogy between these complications and those of duodenal ulcer. In the two diseases, the basic lesion may be clinically silent, or there may be chronic symptoms due to local muscle spasm. In each, an acute process with threatened perforation may appear; the one representing simple acute diverticulitis, and the other, penetrating duodenal ulcer. This process in either lesion may slowly perforate and produce a local abscess, the surgical drainage of which may be followed by a fistula. Further, in both conditions, acute free perforation with general peritonitis is an important complication. Either duodenal ulcer or diverticulitis can produce both chronic and acute intestinal hemorrhage. Duodenal ulcer may produce local stenosis, while a similar process in diverticulitis results in stricture of the colon. A classification of these processes and the number of cases of each are given in Table 1.

CHRONIC DIVERTICULITIS

It is evident from Table 1 that chronic diverticulitis is the most common of all complications of diverticulosis. The patient's complaints and the physical findings seldom are more than suggestive. The most common suggestive symptom is inconstant abdominal pain. This most frequently occurs in the left lower quadrant, but may be of a diffuse, cramping character. Recurring mild diarrhea is the next most common complaint, and usually is not associated with pain. Nine of the fifty-five patients complained of bleeding and in four of these patients the bleeding was massive. These nine cases of bleeding in the chronic diverticulitis group include all the instances of bleeding in the entire series. The only physical finding is tenderness,

which may be present in the left lower quadrant. Sigmoidoscopic examination is usually negative. X-ray study of the colon shows the presence of diverticulosis and narrowing of a segment of sigmoid. The narrowing is usually ascribed to spasm, but may be due to inflammatory swelling or both. Opportunities for correlation of the x-ray and pathological findings are infrequent, and did not occur in this series. Routine roentgenologic study may fail to reveal the disease even when it is well developed. This is due, in part, to the fact that only one out of each three or five diverticula is empty and, therefore, demonstrable at a given time, and in part to the fact that all except the lateral diverticula are overshadowed by the silhouette of the colon. In this connection it should be noted that a twenty-four hour plate may reveal the disease when it was not noted in the original examination. Not uncommonly definite amelioration of symptoms is noted following a barium enema given for diagnosis.

Since in this series no case of chronic diverticulitis was subsequently admitted with a major complication, and since no case in the group of major complications had previously been given a diagnosis of chronic diverticulitis, it seems that the pathological process is usually not progressive. Therefore, the therapeutic problem in this group is entirely medical.

ACUTE DIVERTICULITIS WITHOUT ABSCESS

In this group are twelve of the fifty-nine cases admitted with major complications. (Table 2.) They constitute the most benign form of acute infection and are characterized by the absence of suppuration. Eleven of these patients presented a clinically acute process, initiated by pain in the lower abdomen, associated with localized tenderness and often a palpable mass; and with a low-grade fever and leukocytosis. The lesion shows an inherent tendency to heal spontaneously. Since this syndrome is characteristic of an acute inflammatory process involving a diverticulum, in which perforation does not occur, these cases have been segregated as a distinct group. The twelfth case was one in which death occurred due to pylephlebitis, and at autopsy the cause was found to be simple acute diverticulitis.

Half of this group was correctly diagnosed at the bedside. In each instance conservative treatment was instituted and complete subsidence of the inflammatory process followed. For the remaining cases mistaken diagnoses were made and laparotomies were done in five. In three the preoperative

TABLE 2.—Acute Diverticulitis Without Abscess

12 Cases											
Clinical diagnosis	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Surgery†	No	No	No	No	No	No	Yes	Yes	Yes	Yes	No*
Mortality	No	No	No	No	No	No	No	No	No	No	Yes

* Pylephlebitis.

† Exploration only.

diagnosis was acute appendicitis, in one tubo-ovarian abscess or ectopic pregnancy, and in the other partial intestinal obstruction. In each of these cases the correct diagnosis was made at the time of laparotomy and no definitive treatment was given. In each instance healing occurred. Each of the twelve cases was, therefore, treated conservatively and eleven recovered satisfactorily.

Ten of the patients were followed a significant period of time, and three had further trouble. One had recurring diarrhea for four years and another was admitted to the hospital three times within eight months for recurring attacks of acute diverticulitis which subsided satisfactorily under conservative treatment. The third patient had second admission for the same condition two weeks after discharge and subsided with the same treatment. Four weeks later he was readmitted because of feces passing in the urine. Laparotomy revealed an inflammatory mass in the pelvis and drainage was provided although no definite abscess was found. This procedure was followed by death.

In consideration of the good results obtained, there can be no question but that the utmost conservatism should be practiced in the treatment of the cases in this group. Individualization is necessary where the process tends to recur, and some form of surgical treatment should be considered. Our series does not provide a basis for deciding whether colostomy, resection, or a combination of the two is preferable. Decision regarding this would necessarily depend primarily upon the extent and location of the lesion.

ACUTE DIVERTICULITIS WITH ABSCESS

In this group are sixteen of the fifty-nine cases with major complications. They constitute the group in which acute infection occurs and progresses to suppuration. It is probable that the factor of infection predominates, and that the factor of communication with the bowel lumen is minimal. This is suggested by the fact that, first, an abscess develops; secondly, the abscess is found to contain pus uncontaminated by fecal material; and, thirdly, a fistula seldom develops after surgical drainage of the abscess.

The majority of these patients present a quite characteristic clinical picture. The syndrome is similar to that of the previous group but more marked. The pain and local tenderness are greater. Frequently there is rigidity, and usually a mass can be detected. The general reaction is proportionately greater. While this picture establishes a presumptive diagnosis of acute diverticulitis with abscess, the failure of the process to subside satisfactorily under expectant treatment is the ultimate factor indicating the presence of suppuration.

A summary of this group is shown in Table 3. In six cases a correct diagnosis was made. Three of these were treated by delayed surgical drainage, the fourth drained spontaneously per vaginam, and the fifth drained spontaneously into the lower sigmoid, probably through the diverticulum. All five patients recovered. The sixth patient died after four months, during which time a fistula persisted. At autopsy extensive pelvic suppuration was pres-

TABLE 3.—*Acute Diverticulitis With Local Abscess*

16 Cases			
Number of Cases	Clinical Diagnosis	Drained	Mortality
7‡	No	No	Yes*
5	Yes	Yes†	No
2	No	Yes	No
1	No	Yes	Yes
1	Yes	Yes	Yes

* 2 Pylephlebitis, 1 broad ligament thrombophlebitis, 1 bilateral iliac thrombophlebitis.
 † Drainage spontaneous, 2 cases.
 ‡ The lesion in one case was of right colon.

ent. This patient's unfavorable course should have called for a colostomy.

In the remaining ten cases a correct diagnosis was not made, and two distinct groups are evident. In the first group of four cases the colon lesion was clinically silent, and the symptomatology was due to a secondary vascular complication. In two of these pylephlebitis, with secondary liver abscesses, occurred. In the third the pelvic abscess involved the vessels of the broad ligament and produced lung abscesses. In the fourth case the abscess came into contact with the common iliac vein and produced extensive thrombosis and embolism. Reviewing the records of this group we fail to find evidence which would, in retrospect, suggest the correct diagnosis. Hence, a positive correlation is suggested between the presence of a major vascular complication and an atypical acute diverticulitis. This was also true in the pylephlebitis case indicated in Table 2. In the second undiagnosed group, consisting of six cases, definite symptoms of an acute abdominal condition existed. Various diagnoses were made, and, therefore, none of the cases were properly treated. Only two patients survived. Interestingly, one patient in this group was thought to have an appendiceal abscess, but was in too poor condition for surgical drainage. Autopsy revealed diffuse diverticulosis, with an abscess due to perforation of a diverticulum of the ascending colon. In this connection it should be pointed out that occasionally the sigmoid reaches into the right lower quadrant of the abdomen and can produce diverticular abscess in this location.

Analysis of the cases of acute diverticulitis with local abscess reveals two clearly defined facts: first, a correct initial diagnosis is essential; and, secondly, the proper treatment is delayed surgical drainage. Ideally, the drainage should not be through the free peritoneal cavity. Not uncommonly, and particularly in women, the diagnostic problem will force early intervention. Under these circumstances when abscess is found, simple drainage is indicated. When a diagnosis of acute diverticulitis with local abscess has been made, the patient should be placed on Ochsner treatment, and the progress most carefully followed. If the lesion shows signs of early progression, drainage should be done in order to avoid rupture of the abscess. If the process shows

TABLE 4.—*Acute Diverticulitis With Peritonitis*

26 Cases		
Extent of Disease	Number of Cases	Mortality
General peritonitis	23	23
Local peritonitis	3	0
Treatment		
General—23 Cases		Local—3 Cases
Ochsner	14	Suture and drain 2
Drain	4	Drain only 1
Suture and drain	3	
Colostomy and drain	1	
Colostomy	1	

neither a tendency to progress nor to recede, drainage is indicated. If regression occurs but is incomplete, the stage of chronic abscess has been reached and again drainage is indicated. In this chronic-abscess group it is difficult to avoid the error of assuming that regression has been complete, and of thereby mistakenly placing the case in the category of acute simple diverticulitis. This is an extremely dangerous mistake.

ACUTE DIVERTICULITIS WITH GENERAL PERITONITIS

This group comprises twenty-six cases, constituting nearly half of the acute major complications, and far exceeding in number the cases of stricture and fistula. (Table 4.) This is in marked contrast to the statement in many textbooks that free perforation is a rare complication. The most striking feature of the group is the mortality of 88.5 per cent. Analysis of the clinical histories indicates that there exist two modes of onset. In one group all the cases were admitted in less than one day following the onset of symptoms, with the clinical picture of acute peritonitis. We believe that they represent acute free perforations. In the second group, of practically equal size, all the patients had abdominal symptoms for from three days to three weeks, and there was no case falling between the two groups. It is suggested that the second group consists of simple acute diverticulitis going on to free perforation, or to rupture of diverticular abscess. It is our belief that most of these cases in the second group represent abscesses rupturing because the patient had not come under treatment.

The two groups mentioned in the preceding paragraph present distinctly different problems in diagnosis. In the acute free perforations, the lack of any characteristic antecedent history makes a differentiation from other acute abdominal catastrophes very difficult. However, if the diagnosis of acute diverticulitis is kept in mind in all instances where patients over forty years of age develop an acute severe lower abdominal pain, with almost immediate signs of peritonitis, it is likely that the correct diagnosis can often be strongly suspected. In the second group described, where symptoms have existed for several days before the develop-

ment of the peritonitis, the history of left lower quadrant pain during this time, often associated with diarrhea, should enable one to much more readily make a correct presumptive diagnosis.

Study of Table 4 will show that the only three recoveries were in the only three cases with local peritonitis. All three cases were operated upon; in two the perforation was closed by suture and the peritoneal cavity drained, and in the third, colostomy and drainage were done. It should be pointed out that it may have been the nature of the process, and not the treatment, that conditioned the recovery in these cases. All of the twenty-three patients with general peritonitis died, regardless of whether the treatment was conservative or operative. This mortality rate is no doubt largely dependent upon the high incidence of true fecal peritonitis. On the basis of these results it is difficult to suggest a preferred form of treatment. Although the results from each form of treatment have been uniformly bad, the surgeon still is confronted with the necessity of deciding how to treat the individual case. Commonly, the abdomen will have been opened with a mistaken diagnosis, and diverticular peritonitis will be found. If an acute free perforation has occurred, suture and drainage would seem to be indicated. If a ruptured abscess is found, consideration of the low incidence of fistula, following the drainage of local abscess and the undesirability of further breaking down of the abscess walls, would suggest that carefully placed drainage is logically all that is indicated. If a bedside diagnosis of diverticular peritonitis has been made, some degree of individualization may be possible. If the evidence indicates an acute free perforation, and the condition is of short duration, and the patient is an otherwise good risk, suture of the perforation and drainage seem justified. Under all other circumstances Ochsner treatment should be used. Since the mortality in this group is extremely high, in all doubtful cases decision as to treatment should favor other diagnostic possibilities.

FISTULA

In the entire series there are only four cases of fistula. Each was secondary to an acute process. Two of the fistulae were cutaneous. One of these followed a laparotomy in which a nonsuppurative inflammatory mass was freed, and the abdomen was closed without drainage. A fistula appeared and closed spontaneously in six months. The second followed surgical drainage of an acute free perforation which had been sutured. It closed spontaneously in four months. The other two fistulae both communicated with the urinary bladder, and followed neglected chronic abscesses. These cases were recognized by the passage of gas and feces in the urine, and in neither was colostomy done. Both patients died.

Extreme conservatism is usually practiced in the treatment of cutaneous fistula. Commonly surgical intervention is postponed until a year has passed, and resection is then usually necessary. The spontaneous closure of the two cutaneous fistulae in this series substantiates this attitude. In contrast vesicle fistula has no inherent tendency to heal

spontaneously, and usually requires temporary transverse colostomy, followed later by a direct attack on the fistula. The two cases in this series were not given definitive treatment, and no conclusions can be drawn from them except the prophylactic value of recognizing and draining chronic abscesses.

STRICTURE

In the entire series, stricture occurred in six instances. Four of these were associated with an acute process. In one, exploration was done and simple acute diverticulitis found. Colostomy was required subsequently because of the development of obstruction. The other three cases were admitted because of acute abscess. In each instance there was ultimately proved to be a stricture distal to the infected diverticulum producing the abscess. In contrast to these four cases, two patients were admitted because of intestinal obstruction in which no acute infectious process occurred. Four of these strictures were rectosigmoid, one was six inches above the rectosigmoid junction and the sixth involved the lower descending colon.

The strictures mentioned were all true cicatricial stenoses. Pseudostricture is not uncommon and is often mistaken for true stricture. In the pseudostrictures the narrowing is not due to cicatrization, but is associated with abscess, and is due to extrinsic pressure and intramural inflammation. The profound difference in response to treatment makes it important to recognize this differentiation.

An important aspect of the problem of stricture is its possible relationship to the rupture of diverticula proximal to the site of narrowing. This occurred in three of the six strictures. This susceptibility of diverticula to rupture is further emphasized by two cases in the group of free perforations where the perforations were secondary to obstruction by carcinoma. This is incidentally of importance from a technical standpoint in performing the operation of obstructive resection in the presence of diverticulosis. This danger of rupture has furnished the basis for advising complementary cecostomy in such situations.

When obstruction occurs as the result of stricture, colostomy is necessary. Following this, improvement may be sufficiently marked to permit closure of the colostomy. If improvement does not occur, careful differentiation from carcinoma is necessary. This problem is well known and requires no elaboration. In those cases of stricture where the obstruction does not improve, resection of the lesion can be done if it is located at a sufficiently high level. If the stricture is located too low for resection, the colostomy must be permanent.

IN CONCLUSION

The marked tendency toward spontaneous recovery manifested by acute simple diverticulitis contrasts sharply with the almost uniformly fatal outcome in the acute diverticulitis with general peritonitis. The therapeutic implications, therefore, indicate that intervention is unnecessary in the former and not significantly helpful in the latter. The real problem in therapy is involved

with the abscess factor. Every effort should be made to recognize the presence of abscess, and to intervene if progression occurs, or if regression is either retarded or incomplete.

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CLINICAL NOTES AND CASE REPORTS

EPIDEMIC DIARRHEA OF THE NEWLY BORN*

By BEN B. JOHNSON, M. D.
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AND

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REPORTS of the early outbreaks of epidemic diarrhea of the newly born emphasized the contagious nature of the disease and the high mortality rate. The etiology has not been determined by bacteriological studies of the stools or autopsy investigations. The disease has occurred in modern and efficiently run nurseries, as well as in crowded and understaffed institutions. Breast fed infants were susceptible. No response followed the type of dietary treatment employed in other forms of diarrhea. Isolation or removal of patients to other hospitals and the discontinuance of new admissions were often necessary to control the epidemics.

Subsequent reports stress the value of drastic treatment at the onset of the illness. The death rate is definitely lowered by the use of a continuous intravenous drip of saline and glucose, blood transfusion and short periods of starvation, followed by gradually increasing amounts of protein milk. The danger of temporizing in the treatment of these patients is generally recognized. In the presence of an epidemic, no difficulty in diagnosis is encountered, but the early recognition of the first case is often impossible. It must be differentiated from cases with vomiting and frequent stools due to improper formulas or inability to tolerate cow's milk.

In sporadic cases, one is able to observe more easily the sequence of events. The onset is characterized by listlessness, loss of weight and anorexia. A lowering of the carbon dioxide content of the circulating blood quickly follows the initial symptoms, and may be sufficiently severe to produce acidotic breathing. Vomiting or diarrhea, or both, appear the third or fourth day. The point of utmost significance is this: *the acidosis precedes the intestinal disturbance*. Subsequently the acidosis increases to a degree from loss of base through the diarrhea; but its existence before the onset of intestinal symptoms has been proved by carbon dioxide determinations.

At one hospital a week-old infant became acidotic, with a carbon dioxide content of 19 volumes

* A preliminary report.

PATIENT	TIME OF ILLNESS		Lactate Solution	Result
	SEPTEMBER	OCTOBER		
I	Sept. 10-11	Sept. 12-13	No	Dead
II	Sept. 14-15	Sept. 16-17	No	Dead
III	Sept. 18-19	Sept. 20-21	No	Dead
IV	Sept. 22-23	Sept. 24-25	No	Dead
V	Sept. 26-27	Sept. 28-29	No	Dead
VI	Sept. 30-1	Oct. 2-3	No	Dead
VII	Sept. 4-5	Sept. 6-7	No	Dead
VIII	Sept. 8-9	Sept. 10-11	No	Dead
IX	Sept. 12-13	Sept. 14-15	No	Dead
X	Sept. 16-17	Sept. 18-19	No	Dead
XI	Sept. 20-21	Sept. 22-23	No	Dead
XII	Sept. 24-25	Sept. 26-27	No	Dead

Chart 1.—Results of lactate administration.

per cent, and recovered following the administration of alkali without the development of either diarrhea or vomiting. Although the mechanism responsible for the production of this type of acidosis is obscure, the remarkable response following the use of sixth molar sodium lactate solution* has prompted this report. The correction of acidosis by the use of alkali is, of course, common practice in the management of gastro-intestinal disturbances of infancy. What seems remarkable in this group of cases is the time at which the acidosis occurs, and the insignificance of the primary infection once the acid-base equilibrium has been restored. In cases diagnosed early, lactate may be given subcutaneously without the necessity of additional intravenous fluid. It must be repeated daily until the carbon dioxide content is nearly normal. The statistics in the epidemic to be described illustrate the effectiveness of the therapy emphasized.

COMMENT CONCERNING A RECENT EPIDEMIC

This epidemic occurred in a small hospital near Los Angeles. Among twenty-one patients in the nursery, eleven contracted the disease and four died. The epidemic started when a patient (Case 1), previously isolated because of diarrhea, developed a recurrence after being moved back to the nursery. In Case 2 the patient was admitted with diarrhea contracted at the time of discharge from the nursery of another hospital and was placed in the isolation room with Case 1. The child remained in the isolation room and consequently his relationship to the epidemic is problematical. Each case was in charge of the attending obstetrician until the fourth death occurred. The remaining cases were then supervised by one physician and lactate administration was instituted. Dehydration had been partially combated by the use of glucose and saline. This was given in adequate amounts, but failed to check the progress of the disease. The condition of all but one of these infants was critical. They were exhausted by the severity of the diarrhea and vomiting. Marked abdominal distention was pres-

ent in the cases manifesting clinical acidosis. Feedings by gavage were necessary. All cases receiving lactate solution improved immediately. No deaths occurred in this group.

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OCCCLUSION OF BILIARY SINUS BY BALLOON CATHETER

REPORT OF CASE

By DELL THEODORE LUNDQUIST, M.D.
Palo Alto

A WOMAN, seventy-five years old, giving a history of shortness of breath on exertion, and pain, elsewhere diagnosed as coronary, with a systolic heart murmur and cardiographic changes once interpreted as due to coronary artery disease, consented to operation on April 8, 1937, as the only possible relief for recurrent severe pain (with chills and fever of Charcot type) as pointed out by Dr. George Barnett in consultation. The gall-bladder failed to visualize with dye by mouth on two occasions. With the help of Dr. Edward Liston, an operation was done, consisting of drainage of a fairly normal gall-bladder and removal from it of four irregular bilirubin stones, one of which might have entered the cystic duct. The common duct was explored, without opening it because of falling blood pressure. No great dilatation of it was found, nor any stone palpated therein—only a slight thickening near the ampulla.

After operation, the gall-bladder drainage persisted for three weeks, with a failure to improve in the patient's general condition. There was a suspicion of pancreatic digestion in the wound. Hence, there was made and employed, for the first time in such a sinus, as far as a moderate search of the literature reveals, a device consisting of an ordinary 16 F rubber catheter with a balloon of penrose drain tubing around it and adjacent to its eye. This balloon was constructed by inserting into a hole in the penrose tubing a small (10 F) rubber inflation tube. Using pagenstecher linen, a ligature was made firmly enough about the penrose tubing and the inflation tube to give a tight joint, yet not to occlude the inflation tube. This combination was then slipped over the catheter, and the balloon constructed upon it by ligature of both ends of the penrose tube in a similar fashion. Since that time there have come to my attention the Foley hemostatic bag catheter, for urological use, and the Miller and Abbott¹ double lumen tube for small intestinal intubation. Either of these would probably work just as well in such a site.

The balloon catheter, after boiling, was slipped into the gall-bladder sinus, tied in place to an adhesive strap across the wound and the balloon was inflated through the tube for the purpose, using water injected by a syringe. The bile drainage

* Molar Sodium r-Lactate (Hartman) is converted into sodium bicarbonate rapidly enough to be effective in severe acidosis, without the danger of producing serious uncompensated alkalosis as may occur following sodium bicarbonate administration. It has the additional advantage of being stable and, therefore, not affected by boiling.

¹ Miller, T. G., and Abbott, W. O.: Intubation Studies of Human Small Intestine; Technic for Collection of Pure Intestinal Secretion and for Study of Intestinal Absorption. J. A. M. A., 106: 16-18, (Jan. 4), 1936.

ceased, and the wound healed about the catheter in a few days. For a day bile was allowed to drain freely through the catheter. Then it was possible to clamp it, without external drainage of bile. The patient's stools, which since operation had been "clay-colored," once more became brown.

The balloon catheter was employed for cholangiography later, using iodized oil, with a picture interpreted as showing a filling defect at the ampulla. Hence, Pribram's² method was followed in an attempt to dissolve a possible common-duct stone, without severe reaction, but without help in biliary flow as indicated by a later cholangiography. The second instillation of another type of iodized oil was followed by a severe febrile reaction and suppression of bile (possibly due to free iodine present).

Second-stage operation was done on June 17, 1937, by Dr. Philip K. Gilman and Dr. Liston. T-tube drainage of the common duct was done after exploration and dilatation of the papilla failed to show any stone. Recovery was fairly prompt, as was healing of the sinus after removal of the T-tube on July 4, and of the tube draining the gall-bladder (which had been preserved for a possible cholecystenterostomy) one week later.

The patient has been free of biliary attacks ever since, though she does present a consistently increased blood sedimentation speed.

COMMENT

Nothing original is claimed in this report other than the use of a balloon catheter to effect temporary closure of an external biliary fistula in a poor surgical risk, shunting the flow of bile into the duodenum until such a time as the patient's condition was improved and able to stand a second-stage operation.

The balloon catheter has appeared in many guises: obstetrical, urological, anesthetic, and gastro-intestinal, but so far as a moderate search reveals, this is the first use of it for a biliary fistula. It would seem reasonable that it might be used in intestinal fistulae as well, possibly also for drainage of empyema cavities.

261 Hamilton Avenue.

HIPPOCRATES' APHORISMS*

By M. SCHOLTZ, M. D.
Arcadia

SECTION TWO (Continued)

11. It's easier to sustain the sick
With liquid food than with a thick.
12. The remnants of disease, alack,
Oft harbor dangers of setback.
13. The night before a crisis, as a rule,
The patient feels discomfort and distress;
The night that comes thereafter is quite likely
To bring the patient comfort, more or less.
14. If the quality of feces shows changes,
It can be viewed as a propitious sign,
Unless the change is definitely bad;
Then it portends a dangerous decline.
15. When throat is sore and lumps form on the
body,
Secretions should be watched: if they are
bilious,
The trouble is systemic, and is serious;
If they are normal, it's safe to feed the sick.
16. To a patient who is feeble, wan and spent,
Harsh treatments can bring only detriment.
17. When more food than is proper has been
taken.
It's likely to occasion a disease;
The treatment used to bring about a cure
Will demonstrate and prove this with great
ease.
18. The food which easily assimilated
Produces residue as fast eliminated.
19. In acute disease one cannot tell
Whether the sick will die or will get well.
20. Those who had loose bowels, when quite
young
Turn to be constipated in old age;
While persons constipated in their youth,
Get looser bowels at a later stage.
21. Drinking strong wine
Makes appetite decline.
22. Repletion must be treated by depletion,
And vice versa; thus each morbid state
Is best checked by reverse condition.
23. Acute diseases reach their height
Not later than in a fortnight.
24. There are some days "indicative" in illness
Which help to judge the course of a disease.
These are: the fourth, the eighth, also
eleventh,
And seventeenth—use them as indices.
25. Most summer quartan fevers clear up fast,
But those of fall and winter tend to last.
26. It's safer for the patient when a fever
Succeeds to a convulsion: the reverse
Sequence makes the prognosis so much worse.
27. Improvements in disease, which are not stable,
Cannot be trusted, as they seldom last;
Alike, fear not irregular bad symptoms,
As mostly they are passing and vanish fast.
28. It does not augur well, if in a serious fever
The patient keeps his weight or loses fast:
The first condition means protracted illness;
The latter that the patient may not last.
29. If purging's indicated, have it done
In early stage of illness; do not wait
Until the crisis starts, since at that time
The body should be kept in a restful state.

413 Longden Avenue.

² Pribram, B. O.: *New Methods in Gall-Stone Surgery*, *Surg., Gynec. and Obst.*, 60: 55, (Jan.), 1935.

* For other aphorisms, see *CALIFORNIA AND WESTERN MEDICINE*, March, 1940, page 125; April, 1940, page 179.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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COMMITTEE ON PUBLIC HEALTH EDUCATION*

Your Committee on Public Health Education has announced the state-wide essay contest for high school and junior college students, starting on April 1 and ending on November 1, 1940. The announcement was made in a story to all newspapers and in the official publication of the State Department of Education, which is coöperating fully in the contest. Further news of this important contest will be given as developments occur.

Progress was reported on plans for a motion picture suitable for showing before clubs and schools, to be on a medical subject best suited for the purpose of public education along the lines for which this committee was created.

Your Committee Chairman reported negotiations for securing the services of a statistician to develop full and up-to-date information on compulsory medicine plans and developments in voluntary plans, the information to be used by our speakers' bureaus and in other manner to combat efforts of proponents of compulsory medicine.

Speech No. 49, devoted to exposing the fallacies of compulsory medicine, was mimeographed and forwarded to all speakers' bureaus.

In addition to the story announcing the essay contest, state-wide stories were mailed twice on progress of California Physicians' Service and five state-wide stories were mailed on behalf of the Women's Field Army of the American Society for the Control of Cancer during April,

† For complete roster of officers, see advertising pages 2, 4, and 6.

* The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Karl L. Schaupp, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Dewey R. Powell, Stockton; Charles A. Dukes (ex officio), Oakland. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

the month during which this organization conducts its annual fund-raising and education campaign. Your Committee agreed to furnish this publicity service because of the commendable nature of the organization's work and because the Women's Field Army would have been unable to secure the publicity otherwise.

Copies of the return postcards showing affiliations of members of the California Medical Association were sent to the speakers' bureaus in San Diego and Los Angeles counties, as requested, in order that this important information might be available to the speakers' bureaus secretaries to aid them in their work on behalf of the medical profession.

Speakers' bureaus were mailed copies of the new proposed compulsory medicine initiative that certain labor organizations and others have planned for the November, 1940, ballot. Included in this mailing were two booklets, "Organized Payments for Medical Service," and "Handbook of Sickness Insurance, State Medicine, and the Cost of Medical Care."

Your Public Relations Counsel spoke before the Imperial and Humboldt counties medical societies and before the Pomona branch of the Los Angeles County Medical Society. He also conferred with the chairman of the San Diego County Medical Society Speakers' Bureau regarding supplying new speeches on medical subjects and against compulsory medicine, and arrangements were made to secure these speeches as soon as possible. The Public Relations Counsel also was engaged in preparing and handling the publicity and relations with newspapers for the annual meeting at Coronado.

—R. M.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Four-Point Program for Financing Health Insurance Advanced

Four points for financing American health service were suggested to the Public Health Section by Dr. C. Rufus Rorem of the American Hospital Association, Chicago, in a recent address to the Public Health Section of the Commonwealth Club of San Francisco.

"The health service of the United States," he said, "can best, and probably will, be financed by the following methods:

1. For the indigent and unemployed population, all medical care and hospitalization will continue to be financed through government taxation—local, state, and federal.
2. For the general population, preventive service, tuberculosis and mental care, and treatment of other long-term illnesses will continue to be financed through local, state, and federal taxation.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

3. For the employed population, health service insurance will develop for hospitalized acute illnesses, with benefits including room hospitalization and physicians' and surgeons' services. The medical benefits might be administered in conjunction with or separate from hospitalization. For the low-income groups, tax subsidy may be necessary to bring the premiums within the workers' ability to pay, and to offset the tendency of many workers to obtain both hospital and medical care completely at the expense of the taxpayers.

4. Home and office calls will by and large remain under private practice, even for specialists' services. The 'sliding scale' will become less necessary and more equitable to both physicians and patients, when the hospitalized cases are paid through insurance plans.

"The principle of insurance is particularly adaptable to regularly employed persons and their families, and to acute, unpredictable illness or accident from which complete recovery is the usual result. The American approach to health insurance has been realistic and unique. Most of the plans for sickness and accident protection have given special benefits to the victim of a catastrophic illness or accident. The hospital service plans have far outstripped all other types of voluntary health insurance in number of subscribers, even though they have not included as benefits the services of attending physicians and surgeons."—*The Commonwealth*, April 23, 1940.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

To the Editor:—We would appreciate it if you would give notice, through your JOURNAL, of the postgraduate course in obstetrics for physicians, principally general practitioners, which is offered by the University of Chicago and the Chicago Lying-In Hospital in coöperation with the Illinois State Department of Health and the Children's Bureau, United States Department of Labor.

This course runs from five to six weeks. The only cost to the physicians would be that of their board and room, their own personal incidental expenses, and a nominal fee of \$15. The number accepted for each course will be limited in order that a personal relationship may be maintained between the staff and the physicians. All of the members of the Department of Obstetrics and Gynecology will participate in the program.

Applications and inquiries should be addressed to Postgraduate Course, Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago, Illinois.

We would appreciate any notice that you give of this course.

Very truly yours,

H. CLOSE HESSELTINE, M. D.

COURSE FOR GENERAL PRACTITIONERS
VARIOUS ASPECTS OF CHRONIC DISEASES
JUNE 3 TO 6, 1940
TO BE GIVEN AT THE
UNIVERSITY OF CALIFORNIA HOSPITAL
SAN FRANCISCO
OUTLINE OF COURSE

Monday, June 3

MORNING

9:00—S. R. Mettier, M. D., Treatment of Cervical Osteoarthritis.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary.

9:45—J. F. Rinehart, M. D., Rheumatoid Arthritis.
10:30—L. C. Abbott, M. D., and J. B. Saunders, M. D., The Anatomico-Pathological and Clinical Aspects of Chronic Arthritis.

AFTERNOON

2:00—L. V. Ackerman, M. D., Tuberculosis.
3:00—S. T. Pope, Jr., M. D., Tuberculosis in the Young Adult.
3:30—S. Hurwitz, M. D., Tuberculosis in Childhood.
4:00—F. C. Bost, M. D., Bone Tuberculosis.

Tuesday, June 4

MORNING

9:00—R. S. Stone, M. D., Treatment of Cancer with X-ray.
9:30—E. I. Bartlett, M. D., Cancer of the Lip and Breast.
10:30—C. M. Johnson, M. D., Cancer of the Bladder, Kidney, etc.
11:00—R. Ward, M. D., Malignant Disease of the Thyroid.
11:30—H. B. Stephens, M. D., Cancer of the Lung and Esophagus.

AFTERNOON

2:00—H. G. Bell, M. D., Cancer of the Colon.
2:30—L. Goldman, M. D., Cancer of the Stomach.
3:00—O. W. Jones, Jr., M. D., Intracranial Tumors.
3:30—D. G. Morton, M. D., Cancer of Uterus.
4:00—C. L. Connor, M. D., Early Diagnosis of Cancer.

Wednesday, June 5

MORNING

9:00—D. W. Bennett, M. D., Arteriosclerosis.
9:45—E. S. Kilgore, M. D., Chronic Heart Disease
10:30—O. E. Guttentag, M. D., Chronic Nephritis.
11:15—Evelyn Anderson Haymaker, M. D., Obesity.

AFTERNOON

2:00—C. D. Leake, Ph.D., Chemotherapy.
2:30—M. H. Soley, M.D., Disorders of Thyroid Function.
3:00—S. P. Lucia, M. D., The Treatment of Hemorrhage.

Thursday, June 6

MORNING

9:00—E. W. Twitchell, M. D., The Epilepsies.
9:30—J. Alden, M. D., Care and Management of the Senile Patient.
10:00—P. Poliak, M. D., Chronic Alcoholism in Women.
10:30—P. A. Gliebe, M. D., Involutional or Menopausal Syndrome.
11:00—R. M. Ritchey, M. D., Criminal Psychopathic Personalities.

Tuition Fee.—\$20.

Registration.—Students may register by mail. Please send checks (\$20, payable to the Regents of the University of California) to the Dean's Office, University of California Medical School, Medical Center, San Francisco. In order that arrangements may be made, it is important that all checks be received by the Dean's Office not later than May 29.

This short comprehensive course is designed to meet the needs of physicians engaged in private practice. Speakers will present subject matter from the viewpoint of the chronically ill patient. Many of the discussions will be illustrated by patients, lantern slides or pathological material. Meetings will be held in Toland Hall, first floor, University of California Hospital, San Francisco.

The Students' Cafeteria at the Medical Center will be open for lunch, but not for dinner.

CALIFORNIA PHYSICIANS' SERVICE†

Membership is continuing to increase—10,142 as of April 15. The routine of service is developing and as this development occurs, the administrative work can be done with less and less lost motion.

If the service is to be a success and is to earn a reputation for interest and helpful care for the physicians participating in it, these professional members must help by informing not only themselves, but their assistants, secretaries, and nurses about California Physicians' Service, so that beneficiary members presenting themselves for care for the first time will not be met by statements that the particular office "never heard of California Physicians' Service, etc."

Likewise, success depends upon receiving these patients just as other patients are received, and not as if they were to receive some variety of charitable service at the hands of the professional member.

Instances like the above are not frequent, but they do occur—some because of lack of information on the part of secretaries and nurses—and they are productive of great dissatisfaction and create further difficulty in the attempt to extend the service more widely.

Let us all try to do our informed best to make this Service succeed.

The attention of the professional members is again called to the annual meeting of the administrative members, election of trustees, etc., at Coronado on Tuesday, May 7. During the afternoon the Fee Schedule Committee will hold an open discussion of the fee schedule and suggestions for its revision. All professional members are invited to participate. Likewise, there will be a meeting of deputy medical directors for a general discussion of their problems, and professional members are invited to attend this meeting also. The exact time and places of these meetings will be posted at Coronado.

COUNTY SOCIETIES*

HUMBOLDT COUNTY

The Humboldt County Medical Society held a clinical conference on fractures on March 14. The conference was arranged by the Committee on Postgraduate Education. The visiting instructors were Drs. Frederick Bost and Vern Inman. During the morning and afternoon, clinical cases were presented at the Humboldt County Hospital. A dinner meeting was held at the Eureka Inn at 6:15 p. m., following which Doctors Bost and Inman showed a number of x-ray films of fractures to illustrate cases that were not shown at the hospital. About thirty-five doctors from Humboldt, Del Norte, and Mendocino counties attended this conference. The work covered by Doctors Bost and Inman was of a practical nature, and was very much appreciated by the attending physicians.

The scientific session was followed by a business meeting. Dr. Rupert Hauser of Scotia, California, was voted in as a new member. Dr. L. A. Wing, a former member, was reinstated. Dr. Clarence Vernon Atteberry was voted into membership by transfer from the Los Angeles County Medical Association.

† Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M. D., secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

* For roster of officers of component county medical societies, see page 4 in front advertising section.

The Secretary was instructed to write a letter to the local radio station operator, expressing the appreciation of our Society for removing some of our local irregular practitioners of the so-called "healing art" from his broadcasting program.

A motion was made and carried that our Society go on record as favoring the election of Dr. Henry S. Rogers as president of the California Medical Association. A motion was also made and carried that our Society donate \$50 to the National Physicians' Committee for the Extension of Medical Service.

J. S. WOOLFORD, Secretary.

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SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was held in the Auditorium on February 20, with Dr. Norris Jones presiding.

There were sixty-two members and guests present.

Dr. F. Brewer of the State Board of Health presented a very interesting and instructive sound picture on *Syphilis*. Doctor Brewer was thanked by Doctor Jones for bringing this picture to Sacramento.

Dr. Aurang Shah and Dr. Dellivan Fuiks were unanimously elected to membership in the Society.

Under new business, Dr. Ralph Teall presented a resolution regarding California Physicians' Service. Discussion by Drs. Frank MacDonald, Reardan, and Hale. Doctor Reardan made a motion that the resolution be tabled. The motion was seconded, and passed by a vote of 33 to 9.

Dr. C. E. Von Geldern, Chairman of the Banquet Committee, stated that the banquet was to be held at the Sutter Club on March 16, and asked the members for an opinion as to the price they wished to pay. A motion was passed that the price remain at \$5 per person.

G. E. MILLAR, Secretary.

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on Thursday evening, April 4, in the Medico-Dental clubrooms, Stockton, preceded by the customary supper meeting at the Hotel Wolf, at which twenty-six members and guests were present. A film on *Training the Diabetic Patient* was shown at this meeting by courtesy of the Metropolitan Life Insurance Company. The regular meeting was called to order at 8:30 p. m. by President Hugh J. Bolinger. The applications of Doctors Louis Ghiglieri, Helen L. Starbuck, and Edmund P. Halley having been favorably reported upon by the Admissions Committee, and there being no objections from the floor, they were declared members. The application of Dr. S. F. Priestley for retired membership was read and, on motion of Doctor Powell, was accepted and recommended to the California Medical Association. The resignation of Dr. Peter van der Leek, dated November 1, 1939, was read. This, too, on motion of Doctor Powell was accepted. Dr. Dewey Powell then spoke briefly on the California Physicians' Service and introduced Mr. Sid Robinson, Valley representative of the California Physicians' Service. Frank Doughty reported on the progress of the Speakers' Bureau, stating that any member of the Medical Society could obtain instruction in public speaking at the high school, where a course had been arranged for their use. President Bolinger then passed a coin box for medical aid in China, and a generous response by the members was turned over to Dr. Dora Lee. Dr. Dewey Powell and Dr. G. H. Rohrbacher mentioned that the Woman's Auxiliary to the Medical Society was considering disbanding, and urged that pressure be brought to bear by the Medical Society to forestall this action. President Bolinger then appointed Doctors Ray Owens, A. C. Boehmer, C. V. Thompson, and A. M. Tunnell as a committee for planning

the June meeting of the Medical Society, this committee to arrange for a place to meet, refreshments, and a speaker.

The paper of the evening, *Newer Views on Intestinal Obstructions*, was given by Dr. Homer Woolsey of Woodland Clinic, Woodland. The paper was illustrated by slides and x-ray plates. The paper caused considerable discussion from the floor, and was extremely interesting.

There being no further business to come before the Society, the meeting was declared adjourned at 10 p. m., after which refreshments were served.

G. H. ROHRBACHER, *Secretary*.

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VENTURA COUNTY

The regular meeting of the Ventura County Medical Society was held at Satcoy on Tuesday, March 12, with Doctor Moore presiding. Seventeen members and nine guests were present.

Dr. George Patterson of Los Angeles gave an interesting talk on *Head Injuries from the Standpoint of the General Practitioner*.

Mr. Ross Marshall of the Committee on Public Relations explained the activities of the Committee.

Dr. and Mrs. J. J. Renger (Marie Swezey) were unanimously elected to membership in this Society.

A. A. MORRISON, *Secretary*.

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YUBA-SUTTER COUNTY

The April meeting was called to order at 8:15 p. m. on Tuesday, the 2nd, at the Hotel Marysville, Marysville, the Secretary's report being first read.

Reports of the following committees were submitted: Doctor Hamilton, reporting for the Hospital Relations Committee, stated that "Men attending the regular Friday morning rounds at the Yuba County Hospital are eligible to be on the active attending staff."

Doctor Parkinson, reported for the Postgraduate Committee, outlining the several plans and suggesting that the Society come to a decision regarding one of them.

Doctor Miller was called out, and as the Vice-President was absent the Secretary continued to lead the business of the meeting.

A letter from Dr. Frank R. Makinson and Mr. Ross Marshall, Public Relations Counsel, was discussed, and it was suggested that we appoint a Speakers' Bureau Committee.

Dr. Charles B. Kimmel of Marysville, a member of the Marysville Clinic, was unanimously elected to membership.

Dr. Romaine Whitney, having arrived and taken the chair, the remainder of new business was postponed until the next regular meeting.

Dr. R. Lucian Hamilton introduced Dr. O. W. Jones of San Francisco, who spoke on *Head Injuries and Herniation of Nucleus Pulposus*.

A buffet luncheon followed the address.

There will be no meeting of the Society in May, since it would conflict with the California Medical Association Convention at Coronado.

LEON M. SWIFT, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (61)

Alameda County

Douglas D. Dickson, *Oakland*
Paul Geyser, *Oakland*
Henry A. Perlmutter, *Berkeley*
Arthur R. Twiss, *Oakland*

Fresno County

Frank I. Gilliland, *Fresno*
Kendall B. Holmes, *Fresno*
William X. Okker, *Selma*

Humboldt County

Amy S. Barton, *Adin*
Rupert Hauser, *Scotia*
L. A. Wing, *Eureka*

Kern County

Leo F. Baisinger, *Bakersfield*
J. A. Chapman, *Bakersfield*
Frank J. McDonald, *Bakersfield*
Dee L. Stoops, *Bakersfield*
F. E. Walthall, *Bakersfield*

Los Angeles County

J. Harvey Clark, *Los Angeles*
Joseph Paul DeRiver, *Los Angeles*
Richard C. Dickmann, *Los Angeles*
Douglas Donath, *Los Angeles*
Orwyn H. Ellis, *West Los Angeles*
Morris R. Feder, *Los Angeles*
Maurice P. Foley, *Los Angeles*
Clifton E. Gage, *Los Angeles*
Alex F. J. Hansen, *Long Beach*
Nathan Hiatt, *Los Angeles*
Earl Hyman, *Los Angeles*
Elmer H. Johnson, *Los Angeles*
Floyd H. Kinyoun, *Los Angeles*
Harry N. Krohn, *Los Angeles*
Delia A. Lynch, *Los Angeles*
J. I. Mason, *Los Angeles*
Edward L. McCartan, *Los Angeles*
Charles H. Peppers, *Los Angeles*
Beth Pinkston, *Los Angeles*
Benjamin H. Sherman, *Los Angeles*
Turner B. Smith, *Wilmington*
Lester E. Wight, *Los Angeles*

Merced County

Louis J. Bronstein, *Dos Palos*
Paul A. Lum, *Dos Palos*

Orange County

John McAuley, *Santa Ana*
Allison Reeder, *Newport Beach*

Sacramento County

Delevan Finks, *Sacramento*
Vernon E. Greer, *Galt*
H. W. Rayner, *Sacramento*
Aurang Shah, *Sacramento*

San Bernardino County

P. V. Greedy, *San Bernardino*

San Diego County

Paul F. Siman, *San Diego*

San Francisco County

William H. Banks, *San Francisco*
Franklin A. Hayes, *San Francisco*
Wilhelmina Loewenstein, *San Francisco*
John K. Odegard, *San Francisco*

San Luis Obispo County

Harold L. Graham, *Arroyo Grande*

San Mateo County

Harvey H. Whitney, *Burlingame*

Santa Barbara County

Charles G. Jobbins, *Santa Barbara*
James L. Tobin, *Santa Maria*

*Sonoma County*J. O. Raffety, *Santa Rosa**Tehama County*Roderick A. I. Thompson, *Red Bluff**Ventura County*Dean Gerald Tipton, *Camarillo**Yolo-Colusa-Glenn County*James D. Edmundson, *Orland*Wilfred T. Robbins, *Davis**Yuba-Sutter County*Thomas G. Lupo, *Marysville***Transfers (13)**

C. V. Atteberry, from Los Angeles County to Humboldt County.

James Bird Cutter, from Santa Cruz County to Shasta County.

Howard W. Dueker, from Tulare County to Inyo County.

Roy Fielder, from San Francisco County to Los Angeles County.

W. H. Haakinson, from Imperial County to Santa Clara County.

Vernet H. Heinz, from Los Angeles County to San Bernardino County.

Lionel Jacoby, from Butte County to Alameda County.

Frank E. McCullough, from Alameda County to Sacramento County.

E. A. Patterson, from Alameda County to Fresno County.

Frank F. Schade, from Stanislaus County to Los Angeles County.

Harvey E. Starr, from Fresno County to Los Angeles County.

Wilson Stegeman, from Humboldt County to Sonoma County.

Daniel F. Sullivan, Jr., from Los Angeles County to San Diego County.

Resigned (1)

Joseph A. Daniele, from San Francisco County.

In Memoriam

Ainley, Frank C. Died at Los Angeles, March 16, 1940, age 61. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1906. Licensed in California in 1911. Doctor Ainley was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Bancroft, Martin Flaherty. Died at San Diego, April 11, 1940, age 33. Graduate of Stanford University School of Medicine, San Francisco, 1933, and licensed in California the same year. Doctor Bancroft was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

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Campbell, George Elmore. Died at Los Angeles, February 14, 1940, age 73. Graduate of University of Minnesota Medical School, Minneapolis, 1895. Licensed in California in 1899. Doctor Campbell was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Huggins, Walter Leslie. Died at Los Angeles, April 18, 1940, age 68. Graduate of Albany Medical College, 1899, and University of Southern California School of Medicine, Los Angeles, 1908, and licensed in California the same year. Doctor Huggins was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Hyman, Sol. Died at Los Altos, March 14, 1940, age 65. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1902, and licensed in California the same year. Doctor Hyman was a retired member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Jorgensen, Sophus Nicolai. Died at San Francisco, December 26, 1939, age 71. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1897, and licensed in California the same year. Doctor Jorgensen was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Scott, Alfred James, Jr. Died at Los Angeles, April 17, 1940, age 59. Graduate of University of Southern California School of Medicine, Los Angeles, 1909, and licensed in California the same year. Doctor Scott was a retired member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES**William E. Hopkins
1879-1940**

William E. Hopkins, for many years a member of the San Francisco County Medical Society, died in Los Angeles on February 5, 1940. Doctor Hopkins was born in Winchester, Virginia, on August 3, 1858, and was graduated from the Medical School of the University of Virginia in 1879. In later years he attended the Universities of California, New York, Vienna, and London.

In addition to his large private practice, Doctor Hopkins held the chair of professor of ophthalmology and laryngology at the University of California.

He also served in the United States Army for ten years as a first lieutenant and captain of the Medical Corps, and as colonel in the Spanish-American War.

Doctor Hopkins was well known to a large group of both professional and social organizations throughout the United States, among them being the American College of Surgeons (of which he was a charter member), the American Academy of Ophthalmology and Otolaryngology, the American Laryngological, Rhinological and Otological Society, the Pacific Union Club of San Francisco, the Army and Navy Club of Washington, the University Club of Los Angeles, the Zeta Psi Fraternity, and the Colonnade Club and the Farmington Country Club, both of Charlottesville, Virginia.

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**Frank C. Ainley
1879-1940**

Frank C. Ainley died at the Good Samaritan Hospital in Los Angeles on March 16, 1940, from thrombosis of a branch of the cerebellar artery and consequent complications.

He was born at Perry, Iowa, October 5, 1879, and received his B.S. degree from Drake University in 1902.

His medical degree was granted by Johns Hopkins University in 1906, when he was awarded a position as house officer in the Johns Hopkins Hospital, in obstetrics, for the following year. A year was then spent in Cleveland at Lakeside Hospital, in gynecology, at the end of which time he returned to Baltimore and spent two more years with Dr. J. Whitridge Williams, the last as resident in obstetrics at the Johns Hopkins Hospital. Another year was given to work in the clinics of Vienna and Berlin, and in 1910 he came to Los Angeles, where he gave his entire attention to obstetrics and incidental gynecology. He was one of the very first men in Los Angeles who limited their work to this field, and he did a great deal toward establishing the highest standards of the profession in the southern city.

The salient factors in Doctor Ainley's success were his unquestioned devotion to his patients and their welfare, and his uncompromising adherence to the ideals and principles which he knew to be right. In his professional career and in his private life, he never deviated in the slightest degree from the consistent practice of the old Hippocratic virtues. By his way of life he won the respect and admiration of all who knew him, though he never exerted conscious effort to gain applause or popularity except by the faithful and conscientious discharge of every task that came to his hand. Few knew of his kindness and charity except those who were directly benefited.

Honors came to Doctor Ainley through his merits. He was elected to Phi Beta Kappa and Alpha Omega Alpha, and was a charter member of his Chapter of Nu Sigma Nu. Membership was held in the American Medical Association, the California Medical Association, and the Los Angeles Medical Association. He was a Fellow and charter member of the American Board of Obstetrics and Gynecology. He contributed scientific papers from time to time at various meetings of fellow workers.

Doctor Ainley is survived by his widow and by four brothers, one sister, and nieces and nephews. His friends will retain a clear memory of his loyalty, integrity, and high professional attainments.

R. L. CUNNINGHAM, M. D.
FREDERICK S. RAY, M. D.
VICTOR E. STORK, M. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. FREDERICK N. SCATENA.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Component County Auxiliaries

Alameda County

The annual dinner dance, honoring the husbands of the members of the Woman's Auxiliary to the Alameda County Medical Association, was held at the Athens Athletic Club on Tuesday, March 26. More than three hundred enjoyed the clever floor show and a gay evening of dancing and games.

Following dinner, brief but interesting talks were given by Dr. Charles Dukes, Dr. A. A. Alexander, and Mrs. George Calvin, Auxiliary president.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on publicity, 5867 Whitworth Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Von Hagen and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Success of the affair was due to the committee in charge, headed by Mrs. Frank Baxter, chairman of the evening, and Mrs. George Calvin, President.

Mrs. Ira Church had charge of reservations, Mrs. Roy Nelson was program chairman, Mrs. F. S. Bascom was responsible for the artistic table decorations, and Mrs. C. C. Vardon supervised the games.

On March 15, members of the Auxiliary met at Claremont Country Club for their regular luncheon meeting, Mrs. George Calvin, presiding. Mrs. Clarence Page was hostess of the day.

Health Among the Migrants was the subject of a talk by Dr. Stanford Farnsworth.

Ruth Rapp, Marian Hein, and Marian Hammond entertained with vocal selections. Katharine Andrews accompanied them.

MRS. RENE VAN DE CARR, *Publicity Chairman*.

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Fresno County

On March 5, the Woman's Auxiliary met with the Fresno County Medical Society for a dinner meeting at the University Sequoia Club. After dinner and a short business meeting of the Medical Society, the men welcomed the Auxiliary members and expressed appreciation for the work the women had done in campaigning to defeat Proposition No. 2. The president, Mrs. Kenneth Staniford, and the state president-elect, Mrs. A. E. Anderson, were both called upon for speeches, and graciously responded.

Dr. and Mrs. B. F. Walker both contributed to the program. Dr. and Mrs. Walker have recently returned from an extensive trip around the world, and Mrs. Walker gave a very interesting talk on their trip and Doctor Walker showed colored moving pictures of Bali. Dr. and Mrs. Walker brought many objects of art, which they exhibited after the pictures.

About eighty doctors and their wives were present, and enjoyed a delightful meeting together.

MRS. C. M. VANDERBURGH,
Chairman of Publicity.

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Humboldt County

The Woman's Auxiliary to the Humboldt County Medical Society met for dinner and the Society's regular session on March 14 at the Humboldt Country Club. Mrs. John Chain, Sr., presided.

The guest of honor and speaker of the evening was Mrs. Frederick N. Scatena, State President, who gave an interesting account of the development and purpose of the Auxiliary.

The hostesses were Mesdames O. R. Myers, J. F. Walsh, Edgar Holm, and Mrs. Allan Watson. Twenty-two members were present to welcome Mrs. Scatena.

MRS. MAX GOODMAN, *Publicity Chairman*.

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Los Angeles County

The March 26 meeting of the Woman's Auxiliary to the Los Angeles County Medical Association started off with hearty laughs (thanks to the delightful play by Mrs. L. F. X. Wilhelm) and wound up in a serious and business-like vein.

One hundred twenty-six members and guests met in the auditorium of the Orthopedic Hospital for luncheon.

Mrs. E. Eric Larson presided, and introduced Mrs. Wilhelm, who in turn introduced her guests, all of whom were prominent local clubwomen. Mrs. Wilhelm's play, "Far Above Rubies," was then presented. The curtain rose on a delightful set, supposedly the chic living room of a sophisticated, young, physician's wife (delightfully played by the comely Mrs. George Henry), and the play started off at a lively pace, which it maintained throughout due to the splendid direction of Mrs. Charles E. Futch. The play would be an excellent vehicle for any Auxiliary to produce, either at a regular meeting or for a benefit.

The Nominating Committee submitted the following names for office during the coming year: For president, Mrs. Ralph B. Eusden; for first vice-president, Mrs. Harold F. Whalman; for second vice-president, Mrs. William H. Goeckerman; for recording secretary, Mrs. L. K. Gundry; and for treasurer, Mrs. Jay B. Cosgrove.

Philanthropic work in the Auxiliary, in addition to caring for needy physician's families, was discussed at length. Numerous constructive ideas were suggested by the President, members of the Board, and from the floor.

MRS. WILLIAM BENBOW THOMPSON.

Marin County

The Woman's Auxiliary to the Marin County Medical Society met for dinner on Thursday evening, March 28, at Deer Park Villa in Fairfax. Mrs. C. A. De Lancey presided, and twenty-five members were present.

At the business meeting following dinner, President De Lancey appointed Mrs. Wilson Goddard and Mrs. Rodney Hartman to the Nominating Committee. Mrs. Robert Furlong and Mrs. Carl Clark were nominated from the floor and the name of Mrs. Alfred Schwarz was added.

It was decided to have another "bring your husband dinner" for the May meeting, which will be the last of the season. Mrs. De Lancey is to write the play and members of the Auxiliary are to take various parts.

At the adjournment of the meeting, the Auxiliary joined the Medical Society to hear the joint speaker of the evening, Frederick Williams, journalist and author, who spoke of his experiences as a reporter for the American press in China and Japan.

AGNES CAMPION TAYLOR, *Publicity Chairman*.

Monterey County

On February 1 the Woman's Auxiliary to the Monterey County Medical Society had a bridge luncheon at the Mission Ranch Club in Carmel. Mrs. William F. Coughlin was presiding officer, and there were twenty-six members and guests present. Mrs. Garth Parker gave a financial report on the card party that was held in January, the proceeds of which are to be used to purchase furniture for the children's ward at the County Hospital.

On March 7 the Auxiliary had a dinner meeting at the Forest Lodge in Carmel. Mrs. Spencer Hoyt was then presiding officer, and twelve members and three guests were present. Miss Ena Hoag of the Monterey Union High School faculty was the guest speaker, using as her subject, *My Year in Turkey*, and gave a very interesting discourse on education and government in Turkey. Miss Hoag has successfully mastered the Turkish language, and taught school in Istanbul during 1938-1939. The dinner was also the occasion for the Auxiliary's annual election of officers, and those named to serve the incoming year are: Mrs. Herbert Archibald, president; Mrs. Martin McAuley, vice-president; Mrs. J. H. McPharlin, secretary; and Mrs. Marshall L. Carter, treasurer.

MRS. WILLIAM F. COUGHLIN,
Chairman on Publicity.

San Diego County

Members and friends of the Woman's Auxiliary to the San Diego County Medical Society met for luncheon at the Y. W. C. A. on March 13, Mrs. William Cooke presiding.

A proposed amendment to the State Constitution was read.

Dr. Helen Mackler, luncheon guest, was introduced.

The meeting was adjourned so that all could attend the Public Health Education meeting. The program follows:

PUBLIC HEALTH EDUCATION PROGRAM
Arranged by the Woman's Auxiliary to the
San Diego County Medical Association
Wednesday, March 13, 1940
Y. W. C. A., Tenth and C Streets, San Diego

Session for Parents of School Children

10:00 a. m.

Your Responsibility for the Success of Your Child in School—Mrs. Ada York Allen, County Superintendent of Schools.

Can Your Child Hear?—Durwin H. Brownell, M. D.

Glandular Disturbances of Children—James W. Sherrill, M. D.

Session for Everyone

2:00 p. m.

Vitamins—What? Where? Why?—John C. Schlappi, M. D.

When Your Baby Comes—Roy M. Ledford, M. D.

California Fights Syphilis—Do You?—Helen Mackler, M.D., Bureau of Venereal Diseases, California Department of Public Health.

California Physicians' Service—Hall G. Holder, M. D.

(An explanation of California Medical Association's plan for voluntary health insurance)

IVA O'HARA, *Secretary*.

Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society held the March meeting at Paul's Tea Room in Watsonville on March 25. There were eighteen members present from Watsonville and Santa Cruz.

Miss Julia Koencke, district representative from Salinas, gave a report of the various counties activities. She represented San Mateo, Santa Clara, San Benito, Monterey, and Santa Cruz counties. Mrs. Garth Parker, also of Salinas, accompanied her.

Our president, Mrs. F. P. Shenk, presided over our business meeting. Delegates chosen to attend the convention at Coronado, May 5 to 8, are Mrs. Allen Pederson of Santa Cruz and Mrs. A. F. Giberson of Watsonville, delegates; and alternates to go are Mrs. A. J. Sambuck of Watsonville, Mrs. A. Phillips and Mrs. N. R. Sullivan of Santa Cruz.

MRS. R. C. ALSBERGE.

Stanislaus County

On March 8, the Woman's Auxiliary to the Stanislaus County Medical Society met in the McHenry Public Library to hear a talk by Ben H. Read, Executive Secretary of the Public Health League of California. Mr. Read told of the aims and some of the accomplishments of the League, stressing that they seek to preserve modern, scientific healing arts and that their delegates at the State Legislature are constantly working for measures favorable to this idea.

Fifteen members and eleven guests were present. Following the address, the group adjourned to the home of Mrs. E. R. McPheeters on Kansas Avenue for dessert and an informal meeting, presided over by our president, Mrs. Hans Hartman. The most important business of the evening was the selection of a nominating committee to choose candidates for our election to be held next month.

MRS. WARREN STEELE, JR.

Tulare County

The Woman's Auxiliary to the Tulare County Medical Society met in Visalia on April 1, when the officers elected were as follows: Mrs. Ellis Sox, president; Mrs. R. E. Cronemiller, first vice-president; Mrs. Frank Wiens, second vice-president; Mrs. F. Powell, corresponding secretary; Mrs. H. Falk, recording secretary; and Mrs. D. G. MacKinnon, treasurer.

The group enjoyed a very interesting talk on Honolulu by Mrs. J. W. Irwin of Lindsay.

On April 10, the Woman's Auxiliary will meet at the country home of Mrs. J. C. McClure of Lindsay, past president, for ten o'clock luncheon.

MRS. W. B. PARKINSON,
Corresponding Secretary.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.

American Medical Association, New York, June 10-14, 1940. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Coronado, Coronado, May 6-9, 1940. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Western Section of the American Urological Association, Empress Hotel, Victoria, B. C., July 29-31, 1940. Dudley P. Fagerstrom, M. D., Secretary, 710 Medicodental Building, San Jose, California.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGA	Spokane	

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of May is as follows:

Wednesday, May 1—KECA, 11:15 a. m., The Road of Health.
Saturday, May 4—KFI, 9:45 a. m., The Road of Health;
KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, May 8—KECA, 11:15 a. m., The Road of Health.
Saturday, May 11—KFI, 9:45 a. m., The Road of Health;
KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, May 15—KECA, 11:15 a. m., The Road of Health.

Saturday, May 18—KFI, 9:45 a. m., The Road of Health;
KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, May 22—KECA, 11:15 a. m., The Road of Health.

Saturday, May 25—KFI, 9:45 a. m., The Road of Health;
KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, May 29—KECA, 11:15 a. m., The Road of Health.

Household Hygiene.—An interesting brochure on household hygiene has been brought off the press by J. C. Geiger, M. D., Director of the Department of Public Health, San Francisco, the booklet containing some ninety-six pages with the following major subdivisions: (1) Extinction of Rodents, Insects, Vermin, and Noxious Weeds; (2) Care of Foodstuffs in the Home; (3) Home Care of the Ill; (4) Sterilization of Dishes. The brochure contains much valuable information.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

American Public Health Association: Western Branch.

—The Western Branch of the American Public Health Association will hold its eleventh annual session in Denver, Colorado, June 23 to 27, 1940. The program will be devoted to a discussion of public health matters of special interest to physicians in practice in the Pacific Coast states. For further information address Dr. A. L. Beagler, Director of Health Service, Denver Public Schools, Denver, Colorado, or W. F. Higby, 45 Second Street, San Francisco.

Control of Venereal Disease.—A state-wide campaign has been launched in California, initiated by the California Department of Public Health in cooperation with the State Board of Pharmacy and the United States Public Health Service. Pledge cards were sent to 142 drugstores in Oakland, California, asking for cooperation in the venereal disease control campaign. To each druggist who signed this pledge went an engraved certificate of cooperation, to be displayed on the walls of the drugstore. The certificate stated what the store will do and what it will not do. The store identified with the movement to help stamp out venereal diseases pledged itself *not* to "sell medicines for the self-treatment of venereal diseases except upon the order of physicians' prescriptions. The store *will* refer all patients to a physician or health clinic." To date, 121 drugstores in California have signed pledges. Only one has refused.

Another Remedy Found from Work on Maggots.

Following the medical discovery of the remarkable effectiveness of sterile blowfly maggots in healing stubborn wounds in human beings, Dr. William Robinson of the United States Bureau of Entomology and Plant Quarantine has continued investigations of the way maggots bring about such satisfactory results. He now finds that maggots produce a common and inexpensive chemical, ammonium bicarbonate, and that this compound stimulates healing similar to the healing by the maggots themselves.

Reporting to the medical profession through the *American Journal of Surgery*, the federal scientist makes his third announcement of healing substances produced by the maggots. In 1935 Doctor Robinson discovered that allantoin, which occurs in the secretions of maggots, heals wounds rapidly. The following year he found that urea, a simpler chemical, acted similarly. Ammonium bicarbonate is still a simpler chemical compound and is formed naturally from urea by the action of an enzyme called urease.

After testing the ammonium bicarbonate solution on animals, Doctor Robinson obtained the cooperation of physicians and surgeons, some of whom had previously used allantoin and urea. His report in the *Journal of Surgery* is largely a summary of their professional experience in treating infected wounds that did not yield to other methods. A one per cent solution proved effective when used either as a wet pack or as an irrigation of an open wound. Some of the conditions cleared up by the new treatment were: chronic osteomyelitis, diabetic and varicose ulcers, middle-ear infections, stich abscesses, infected lacerations, and other purulent wounds.

American Association of Industrial Physicians and Surgeons.—The twenty-fifth annual meeting of the American Association of Industrial Physicians and Surgeons, together with the first annual meeting of the American Industrial Hygiene Association, will be held at the Hotel Pennsylvania, New York City, June 4-8, 1940. This will be a four-day convention intensively devoted to the problems of industrial health in all of their various medical, technical, and hygienic phases, with particular stress on prevention and control of occupational hazards. Important programs have been prepared, and technical and scientific exhibits will be a feature of the Convention. The dinner on Thursday evening, June 6, will be the occasion of the presentation of the William S. Knudsen award for the year of 1939-1940. The medical profession is not only invited, but urged to attend these gatherings as they will be of unusual interest and value to all practitioners interested in industrial injuries and illnesses. For further information, address Armour G. Park, 540 North Michigan Avenue, Chicago, Illinois.

Southern California Medical Society.—The one hundred and second semi-annual meeting was held April 19-20, at the Los Angeles County Medical Association Building, 1925 Wilshire Boulevard, Los Angeles. Program follows:

Friday Afternoon Session, April 19, 2 p. m.

Recent Developments in the Treatment of Urinary Infections—Harry A. Zide, M. D., Los Angeles.

Discussion by Frederick A. Bennetts, M. D., Los Angeles, and Benjamin H. Hager, M. D., Los Angeles.

SYMPOSIUM—SYPHILIS

The Laboratory Diagnosis of Syphilis—Edward M. Butt, M. D., Los Angeles.

Problems of Acute Syphilis—Kendal Frost, M. D., Los Angeles.

Latent and Wassermann-Fast Syphilis—Julius Scholtz, M. D., Los Angeles.

Neurosyphilis: Principles of Treatment—C. Russell Anderson, M. D., Los Angeles.

Problems in Late Symptomatic Syphilis—William Goeckerman, M. D., Los Angeles.

Friday Evening Session, April 19, 8 p. m.

The Clinical Use of the Vitamins—Dwight L. Wilbur, M. D., San Francisco, Associate Clinical Professor of Medicine, Stanford University School of Medicine.

Saturday Morning Session, April 20, 10 a. m.

A Régime for the Treatment of Acute Head Injuries—Mark A. Glaser, M. D., Los Angeles.

Discussion by John F. Van Paing, M. D., Santa Barbara, and Rupert B. Raney, M. D., Los Angeles.

Some Newer Aspects in the Problem of Child Feeding—Clement J. Molony, M. D., Los Angeles.

Discussion by Howard R. Cooder, M. D., Los Angeles, and John C. Wilcox, M. D., Pomona.

Acute Hepatitis of Alcoholism: A Clinical and Laboratory Study—Horace B. Cates, M. D., Los Angeles.

Discussion by Emile Bogen, M. D., San Fernando, and Eaton M. MacKay, M. D., La Jolla.

Thrombosis of the Mesenteric Veins—Carl Doehring, M. D., Pasadena.

Discussion by Alvin G. Foord, M. D., Pasadena, and E. Eric Larson, M. D., Los Angeles.

The Influence of Mechanical Factors on Arteriosclerosis—A. J. Leser, M. D., Los Angeles.

Discussion by Noel F. Shambaugh, M. D., Long Beach, and Ernest M. Hall, M. D., Los Angeles.

Business Meeting.

Saturday Afternoon Session, April 20, 2 p. m.

Incidence of Carcinoma Associated with Complete Prolapse of the Uterine Cervix—Douglas Donath, M. D., Los Angeles.

Discussion by Henry N. Shaw, M. D., Los Angeles, and William E. Costolow, M. D., Los Angeles.

SYMPOSIUM—COMPLICATIONS OF PREGNANCY

Early Hemorrhage—Leon Krohn, M. D., Los Angeles.

Late Hemorrhage—Thomas J. O'Neill, M. D., Los Angeles.

Toxemia—Philip A. Reynolds, M. D., Los Angeles.

Dystocia—A. M. McCausland, M. D., Los Angeles.

Podalic Version and Breech Extraction—B. J. Hanley, M. D., Los Angeles.

American Medical Golfing Association Golf Tournament.—The American Medical Golfing Association will hold its twenty-sixth annual tournament at the Winged Foot Golf Club, Mamaroneck (Westchester County), New York, on Monday, June 10. Members may tee off from 7:30 to 2 p. m.

Fifty Trophies and Prizes.—Thirty-six holes of golf will be played in competition for the fifty trophies and prizes in the eight events.

Two Eighteen-Hole Championship Courses.—The twenty-sixth tournament of the American Medical Golfing Association at Winged Foot promises to be a wonderful affair. The Club is one of the most elaborate in the country, with a beautiful clubhouse and two sporty courses. The American Medical Golfing Association officers anticipate that some 250 to 300 medical golfers from all parts of the United States will play thirty-six holes in New York on June 10.

Application for Membership.—All male Fellows of the American Medical Association are eligible and cordially invited to become members of the American Medical Golfing Association. Write Executive Secretary Bill Burns, 2020 Olds Tower, Lansing, Michigan, for application blank. Participants in the American Medical Golfing Association tournament are required to present their home club handicap, signed by the Club secretary, at the first tee on the day of play. No handicap over thirty is allowed. Only active Fellows of the American Medical Golfing Association may compete for prizes. No trophy is awarded to a Fellow who is absent from the annual dinner, which is always worth while waiting for!

Great Quantities of Medical Stores Bought by Red Cross for War Relief.

—Medicines, hospital and surgical supplies loom large in American Red Cross war relief purchases, according to a recent tabulation of articles which that organization is furnishing its sister societies in war-affected countries to assist them in minimizing the sufferings consequent to hostilities.

Analysis of the tabulation, dated April 1, reveals the following purchases:

500,000	tablets of sulfanilamide
266,000	tablets of sulfapyridine
100	tons of other assorted drugs
23,000	surgical instruments
38	X-ray units
32	generating motors for x-ray units
1	100-bed hospital unit, containing 700 items
25	hospital tents each of fifty-patient capacity
11	motor ambulances
1,500,000	yards of surgical gauze
92,000	pounds of absorbent cotton for medical purposes
276,000	yards of bed sheeting and large quantities of soap, toothbrushes and other similar products

Purchases for relief also included 120,000 blankets, 105,000 suits of knitted underwear, 45,000 pairs of shoes, and various other articles of clothing. In addition, women volunteers in Red Cross chapters all over the country have produced 344,000 garments and 500,000 surgical dressings. These are sent to the Red Cross warehouse in New York, where they are packed and shipped to the various Red Cross societies in the nine European countries currently receiving assistance. These are: Finland, German-occupied Poland, France, and England; and Latvia, Lithuania, Rumania, Hungary, and Yugoslavia. These latter five countries harbor some 122,000 Polish soldiers and civilians who sought refuge there last September.

American Red Cross relief operations in Europe are under the supervision of a commission of two men, James T. Nicholson, from National Headquarters, Washington, and Wayne Chatfield-Taylor, former assistant secretary of the Treasury. With central offices at Geneva, they are in a position to visit the various relief fronts and personally supervise distribution of supplies and ascertain future needs.

Medical School to Offer Graduate Courses in June.

The University of California will give the second of its 1940 series of refresher courses for graduate physicians June 3 to 6 at the Medical Center in San Francisco. All sessions will be held in Toland Hall, University of California Hospital.

The short, intensive course, designed to meet the needs of physicians in practice, will cover various aspects of chronic diseases and will include a discussion of the problems of cancer, heart disease, arthritis, kidney disease, mental diseases, and tuberculosis. Lectures will be illustrated with actual cases, lantern slides, or pathological material. Detailed programs may be obtained from the office of the dean.

Library Exhibit at University of California Medical School.

During the past few months several interesting exhibits have been arranged in the Crummer Room and in the Main Reading Room of the University of California Medical Center Library. These exhibits have related to the evolution of the stethoscope, the life of Beverly Cole, M.D., postage stamps of medical interest, and the evolution of a book from rough manuscript to final printing. Dr. K. F. Meyer, Professor of Bacteriology and Director of the Hooper Foundation, has arranged a comprehensive and complete exhibit relating to postage stamps of medical interest. The full details of the situation or man pictured by the stamp have been included, as well as various states of issue of the stamp together with pertinent philotechnical information. The exhibit on Beverly Cole, M.D., was arranged by Mrs. Frances Tomlinson Gardner, librarian of the Crummer Room for medical history and bibliography, who has prepared an interesting biographical sketch of the life of Cole. This biographical tract includes much hitherto unnoticed material relating to the vivid leader in San Francisco medicine in the last half of the nineteenth century. Mrs. Gardner's biography of Cole will be published in the *Annals of Medical History*.

A New High Level in the Probability of Dying from Cancer.

The elimination of cancer as a cause of death would increase appreciably the average length of life. If this disease had been nonexistent in 1937, the average length of life corresponding to mortality conditions of that year would have been 1.82 years greater in the case of white females and 1.17 years greater in the case of white males. These figures constitute a measure of the toll this disease takes. If these gains could be realized, they would bring with them not only longer life, but the elimination of much human suffering as well.

But medical science does not, as yet, give even a hint of the elimination of cancer from its position as the second most important among the causes of death and, therefore, it still remains a serious question to determine what are the average individual's chances of eventually dying from this cause. A study of current statistics indicates that, if present conditions of mortality remain unchanged, cancer will take as its toll by death about fourteen out of every one hundred women and about twelve out of every one hundred men. Not quite twenty years ago the chances of eventually dying from cancer were about twelve in one hundred for women and nine in one hundred for men. These figures relate to white persons of adult ages in the general population of the United States in 1937 and in 1920, respectively.

The chance of eventually dying from this cause naturally increases, to some extent, with advance in age, since cancer is essentially a disease of late life.

It may seem an anomaly that, at the higher ages of life, the chances of eventually dying from cancer should become less, despite the fact that the disease has its greatest incidence at these very ages. The explanation is not hard to find. Although the death rate from cancer increases

with age, at the very high ages it does not increase as rapidly with advance in age as does the death rate from causes other than cancer—in particular, cardiovascular conditions. As a result, at the high ages, the chances of eventually dying from some cause other than cancer must necessarily increase, and, since ultimate death from one cause or another is a certainty, the chances of eventual death from cancer will diminish. . . .

American Congress of Physical Therapy.—The eighth annual seminar of the Western Section of the American Congress of Physical Therapy will be held on June 3 and 4 at San Francisco, in the Fairmont Hotel, California and Mason streets. The program follows:

Monday, June 3, 9 a. m. (Morning Session)

Fred B. Moor, M. D., College of Medical Evangelists, Loma Linda, Presiding

- 9:00-10:00—Registration and Inspection of Exhibits.
- 10:00-10:05—Address of Welcome, John S. Hibben, M. D., Chairman of the Western Section, American Congress of Physical Therapy.
- 10:05-10:30—The Treatment of Erysipelas by Ultraviolet Light, H. Glenn Bell, M. D., University of California Medical School.
- 10:30-11:00—The Nature and Chemical Effects of Ultraviolet Light, G. K. Rollefson, Ph.D., University of California.
- 11:00-11:30—Infra-Red Photography, John B. de C. M. Saunders, M. B., F. R. C. S. (Edin.), University of California Medical School.

Monday, June 3, 2 p. m. (Afternoon Session)

Clinton DeWitt Hubbard, M. D., Huntington Park Presiding

- 2:00-2:30—The Postural Syndrome, A. Merton Bassett, M. D., University of California Medical School.
- 2:30-3:00—Diathermy in the Treatment of Bronchitis and Bronchiectasis, Alice Potter, M. D., University of California Medical School.
- Discussion opened by G. Bernard Robeson, M. D., Stanford University School of Medicine.
- 3:00-3:30—Local Heating in Pelvic Pathology, John R. Upton, M. D., University of California Medical School.
- Discussion opened by Fred B. Moor, M. D., Loma Linda.
- 3:30-4:00—Freezing in Malignancy, Eric Liljencrantz, M. D., Stanford University School of Medicine.

Monday, June 3, 6:30 p. m. (Evening Banquet Session)

William Reilly, M. D., President, San Francisco County Medical Society, Toastmaster

Round-Table Discussion: W. H. Northway, M. D., Stanford University School of Medicine, Leader.

Tuesday, June 4, 9 a. m. (Morning Session)

G. Mosser Taylor, M. D., Los Angeles, Presiding

- 9:00-9:30—Differential Diagnosis and Treatment of the Lumbosacral and Sacro-Iliac Pathology, Joseph C. Risser, M. D., Los Angeles.
- 9:30-10:00—Types of Low Back Pain and Sciatica Found in Association with Dislocations of Intervertebral Discs, O. W. Jones, M. D., University of California Medical School.
- Discussion of two preceding papers opened by LeRoy C. Abbott, M. D., University of California Medical School.
- 10:00-10:30—Anatomical Discussion of Subluxations of the Spine: Manipulative Correction, Verne T. Inman, M. A., Ph.D., M. D., University of California Medical School.
- 10:30-11:00—Anxiety States and Their Physiological Manifestations, Mayo H. Soley, M. D., University of California Medical School.
- 11:00-11:30—Physical Therapy in Psychiatric Practice Ernest G. Lion, M. D., Stanford University School of Medicine.

Tuesday, June 4, 2 p. m. (Afternoon Session)

Alexander Silverglade, M. D., Oakland, Presiding

- 2:00-2:30—Orthoptics, S. F. Boyle, M. D., Stanford University School of Medicine.
- 2:30-3:00—Role of Spa Therapy in Chronic Degenerative Diseases, Charles Singer, M. D., Health Resort Commissioner, Long Beach, New York.
- 3:00-3:30—Pool Therapy for Arthritis, Lucile Eising, M. D., Children's Hospital, San Francisco.
- Discussion opened by Joseph C. Risser, M. D., Los Angeles.
- 3:30-4:00—The Treatment of Injuries to the Soft Tissues, B. Paul Davies, M. D., Stanford University.
- Discussion opened by G. Mosser Taylor, M. D., Los Angeles.

Basic Principles of the Internship.—The following resolutions were unanimously adopted by the Advisory Council on Medical Education in February, 1940.

Inasmuch as the internship is now universally regarded as a part of the basic preparation for the practice of medicine, and to be fully satisfactory must be integrated with the medical course proper, the Advisory Council on Medical Education recommends that the Association of American Medical Colleges, in coöperation with national medical and hospital organizations and the Federation of State Medical Boards and state licensing bodies and after consultation with the Council on Medical Education and Hospitals of the American Medical Association, should formulate minimum educational standards for the internship and should prepare a list of hospitals in this country which meet these standards.

Inasmuch as the internship is now universally regarded as a part of the basic preparation for the practice of medicine, the Advisory Council on Medical Education recommends to the Federation of State Medical Boards that an internship of not less than twelve months and of satisfactory educational content be required for admission to the state licensing board examinations in all states.

Basic Principles of the Internship:

1. The internship should be regarded as a part of the basic preparation for either beginning the general practice of medicine or undertaking advanced training in a specialty.

2. The internship should provide a real educational experience and a period of clinical responsibility under supervision which aims to complete the clinical clerkship of the medical course.

3. The internship should be an important responsibility of the staff and be under the direction of those members who are competent to provide the necessary instruction.

4. The internship should be a joint responsibility of the medical schools and of those hospitals which can provide a satisfactory completion of the fundamental preparation for medical practice.

Believing that the public interest as well as that of the medical profession and of medical education would be served by a satisfactory method of interstate endorsement of licensure, the Advisory Council on Medical Education recommends to the Federation of State Medical Boards that all state licensing boards endorse without further examination the licensure of an applicant previously obtained by examination in another state whose standards of education and examination are not lower than their own, provided that the applicant is a graduate of a medical school in the United States and its possessions which at the time of his graduation was on the list of approved medical schools.

Recognizing the widening public, cultural and educational interests of medicine, the Advisory Council on Medical Education recommends to the Association of American Medical Colleges, the Association of American Universities, and the Association of American Colleges that the college preparation for medical studies above the necessary grasp of the fundamental principles of biology, physics, and chemistry should be devoted to general education rather than additional forms of preprofessional education.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Public Wrath Halts Hospital Strike Threat

Emergency Meeting Between Cleary, Labor Leaders Called; Council Asks for "Fairness"

Faced with a wave of public indignation and the certainty of stern action by the city government, labor leaders yesterday withdrew the immediate threat of a strike against ten San Francisco hospitals.

All plans for the strike will be held in abeyance pending an emergency meeting to be held either today, or tomorrow morning at the latest, between a special San Francisco

Labor Council committee, Chief Administrator Alfred J. Cleary, Dr. J. C. Geiger, health director, and representatives of the hospitals and of the San Francisco Employers' Council.

Hold Meeting

This was the result of an eleven hour meeting at the Labor Temple, during which representatives of the American Federation of Labor Hospital and Institutional Workers' Union, determined to proceed with strike plans regardless of consequences, were dissuaded from hasty action by Doctor Geiger and State Senator John F. Shelley, President of the San Francisco Labor Council and chairman of the special committee, which includes Lawrence Palacios and Milton Maxwell, prominent labor executives.

The Union had set a deadline of six o'clock this morning, after which, if the hospitals refused to grant wage adjustments or arbitrate them, the members of the Union would go on strike.

Shelley, Palacios, and Maxwell met previously with Almon E. Roth of the San Francisco Employers' Council, and they had worked out a plan for a five-day truce, pending further discussion of the dispute. . . .—*San Francisco Examiner*, April 21, 1940.

Strike in Hospitals Would Be Blunder

The threatened strike of institutional workers in San Francisco's private hospitals would be a serious and stupid blunder on the part of organized labor.

Nothing would more quickly and permanently destroy public sympathy in and respect for organized labor than an inconsiderate and reckless strike against the sick and the infirm.

It would be in all ways against public welfare, public safety and public health.

Certainly if labor desires to alienate public support and confidence, a hospital strike would accomplish it.

It is unthinkable and inconceivable that responsible and intelligent labor leadership could contemplate such a strike.

In such a situation, it would be the inevitable inclination and the inescapable duty of the general public not only to oppose and resist, but to bitterly condemn and actively break the strike effort.

A strike against public health is entirely intolerable and unendurable.

Hospitals are institutions of mercy, and of the relief of pain; and to all who enter their ministering portals they are refuges of hope—to many they offer the last hope for life and happiness.

To abandon or neglect the sick would be the highest of crimes on the part of doctors, nurses, druggists, or others whose duty it is to attend them and whose vital talents make the restoration of health possible.

No less vital to the sick are the indispensable services of the institutional workers, without whom effective hospital functions could not be performed.

Does organized labor in San Francisco wish to be condemned and feared by public opinion?

Does it wish to have it said that it sought to capitalize upon the sufferings of the maimed and diseased, the bed-ridden and helpless?

This is not a question of labor and capital, but of simple humanity.

Let Labor squelch this stupid blunder within its own ranks.

Labor's decision yesterday to defer action pending a conference with responsible city officials was an encouraging sign of a return to sanity. And Labor must return to sanity in this instance if it is to retain public respect and confidence.

Labor should be with the people, not against them.—*Editorial, San Francisco Examiner*, April 21.

American Medical Association Files Appeal in Supreme Court

Washington, April 29 (AP).—The American Medical Association told the Supreme Court today that the Sherman Anti-Trust Act was intended to be "a commercial statute" and not "to cover acts done in the field of the learned professions."

This assertion was made in appealing from a decision holding that the association and a group of individual physicians must stand trial in the District of Columbia on charges of violating the anti-trust law by activities against a group health association.—*San Francisco Examiner*, April 30, 1940.

Doctors Announce Essay Contest, to Begin Immediately

Realization of the important rôle played by doctors of medicine in the life, health, and happiness of the people will be stressed in an essay contest, with prizes, for high school students of California, announced today by the

Committee on Public Health Education of the California Medical Association.

The contest, extending from April 1 to November 1, is being announced also in the April issue of *California Schools*, publication of the State Department of Education, with the cooperation of Aubrey A. Douglass, chief of the division of secondary education.

The subject of the essays is to be "The Role of Medicine in the Life and Health of the American Citizen," and it is open to students who will be in the tenth, eleventh, and twelfth grades of high schools and junior colleges in California next fall.

There will be three major prizes and five minor prizes in money, and attractive certificates also will be awarded winners.

Essays will be limited to three thousand words and may be typewritten on one side of the paper if possible, although those neatly written in longhand will be equally acceptable. All essays will be returnable to the Committee on Public Health Education, California Medical Association, Essay Contest Department, 450 Sutter Street, San Francisco.—Nevada City *Nugget*, April 5.

Doctors Map Health Plan

Formation of a number of the nation's physicians into a committee to devise means of providing medical service to indigents and those in the lower income brackets while maintaining the system of independent medical practice was announced yesterday in Chicago.

The committee, to be known as the National Physicians' Committee for the Extension of Medical Service, consists of a central committee of 452 members and claims it has 25,000 physicians voluntarily contributing to its support.

It is not proposed to establish clinics, local members of the committee explained. Rather the purpose of the committee will be to keep the public advised of methods, progress, and achievements of American medicine and to promote widespread distribution of medicine and surgery.

Numerous members already contribute their services to various established clinics and will continue to do so.

The new committee is independent and nonprofit.

Of particular concern to the committee will be the class or "near-indigents" or "medical-indigents," people able to supply themselves with basic needs but unable to take care of unforeseen illnesses or injuries.

Dr. Edward H. Cary, Dallas, is chairman of the executive board. Dr. Charles A. Dukes, Oakland, is a member of the executive board.—San Francisco *Chronicle*, April 7.

Number of United States Doctors Gains

Chicago, April 4 (AP).—The number of physicians in the United States has increased by 1,379, not including immigrant doctors, the *Journal of the American Medical Association* reported today.

The figure was arrived at by deducting the number of physicians' deaths from the number of graduates of medical schools for the year ended June 30, 1939.

The annual analysis of physician mortalities reported that the average age at death was 66.1, compared with 65.6 in 1938.

"Heart disease was again the leading cause of death, as it has been for many years," the survey said.—Long Beach *Press-Telegram*, April 4.

Bourbon Groups Meet in Fresno to Outline Plans

Patterson Slate Endorses Program; Garner Backers Attack Ickes

Fresno, April 1.—A slate of candidates for membership on the California delegation to the Democratic National Convention, headed by Lieutenant-Governor Ellis E. Patterson, meeting here on Saturday, outlined a tentative platform to be submitted to a state-wide convention of Democrats to be held in Fresno on April 13 and 14.

R. W. Borough of Los Angeles, who presided, said the proposed platform may be changed, and that the issues will be subject to additional discussion before adoption at the convention.

Issues are Listed

The following issues were listed in a statement by Patterson: . . . "Compulsory medical, surgical, and hospital care for all people in the country earning less than \$3,000 must be provided." . . . —Modesto *Bee and News Herald*, April 1.

Hospitals Should Be More Inviting, Conference Told

Patients Should Be Treated Like Guests of Honor, Association President Advises Delegates

Hospitals should be made as inviting as the home—

And each patient should be made to feel as if he were the special guest of honor.

This advice in hospital operation methods was offered yesterday by Dr. Fred G. Carter, President of the American Hospital Association and Superintendent of St. Luke's Hospital of Cleveland, Ohio.

He delivered his message before three thousand delegates attending a four-day session of a joint meeting at the Biltmore of the Association of Western Hospitals and the Western Conference of the Catholic Hospital Association.

Officers Elected

Ellard L. Slack, administrator of Samuel Merritt Hospital, Oakland, was elected president of the Association, succeeding Harold S. Barnes of Salt Lake City.

Other officers named are Dale L. Smith, administrator of Santa Fe Lines Hospital, Los Angeles, first vice-president; Sister John of the Cross, consultant of the Mt. St. Vincent Hospital, Seattle, second vice-president; and Arthur G. Saxe, administrator of Mt. Zion Hospital, San Francisco, treasurer.

The new officials will be installed at the concluding program tomorrow.

Should Abolish Fear

Hospitals must be planned and operated with the thought of encouraging people to enter them without fear, Doctor Carter declared at a panel discussion on institutional policies.

"And when patients leave the hospital," he added, "they should feel that everything possible has been done for them."

"They are interested in the people they meet and the things that they say and do. They are interested in the general atmosphere—whether or not it reflects hospitality, graciousness, kindness, courage, cleanliness, genuine interest and all the other things that impress people favorably or unfavorably. . . ."

Rev. Paul R. Zwilling of St. Louis, Missouri, President of the American Protestant Hospital Association, was principal speaker at another panel discussion on "The Spirit of Hospital Service."

"Nowhere in all the world has medical science made such progress as in America, and nowhere has more been done for the medically indigent," he said.

Advice Offered

Hospital staff members should take a tip from hotel operators, he advised, and familiarize themselves with the patient's name and use it on every possible occasion.

"Nothing about a person," he elucidated, "is more individualistic than his name, because it differentiates him from almost everybody else in the world."

"No person likes to be referred to as a room number, or as the appendix in 203, a hot tube, a dope, a crack-up, or any of the other familiar terms heard around hospital corridors."

Patients like to feel that they are important, Doctor Carter pointed out, adding that there are numerous ways of gratifying this wish.

Way to Make Friends

"No matter how many patients there are in a given hospital the ills of the individual patients are the most important to him and the members of his family," he declared.

"With a little effort his importance can be emphasized and personalized in a way that will be greatly appreciated and at the same time make friends for the hospital."

Hospital administrators must constantly keep before the public eye the service they aim to render to the community, the speaker emphasized.

"Let us remind our friends," he said, "that through various prepayment hospitalization plans, as they are being sponsored by the hospitals, we are endeavoring to help them carry the load of every emergency."

"Let us hope that our physician friends will give the prepayment plan serious consideration and keep it on a high and ethical plane rather than have some radical scheme foisted upon them, which will give to medicine, as we know it, the death blow."—Los Angeles *Times*, April 10.

One Hundred Eighty Thousand American Children Die Needlessly Each Year as Science Offers Means of Cutting Mortality

Each year 180,000 American children die needlessly, Wilburt C. Davidson, M.D., declares in *The Journal of the American Medical Association* for March.

"The thirty-seven conditions which cause 56 per cent of the annual 240,000 deaths among American children," he says, "can and will be prevented if the public is educated by publicity to utilize the resources of the medical profession. Especially is this true of the measures for better care during pregnancy and after birth." In addition, he points out, 21,000 of the total number of deaths among children are due to curable diseases.

"Unfortunately," Doctor Davison continues, "the diseases peculiar to early infancy kill nearly as many now as in 1898. In order to insure the greatest health to an infant, the prevention of disease should commence as soon as the mother knows she is pregnant, as her health as well as that of her unborn infant is greatly affected during this period. The changes in organs are sudden. There is a double load on the heart and kidneys. The importance of diet and its effect on both mother and child cannot be overemphasized. Disease of the mother, heart disease, tuberculosis and syphilis, also is an important cause of mortality soon after birth. No patient requires more frequent and detailed checking than does the expectant mother.

"The causes of deaths among children which can be prevented by better care during pregnancy and delivery and immediately after birth include prematurity, birth injuries, suffocation, impetigo (a skin disease) and syphilis.

"Sixty per cent of infant deaths occur in the first month of life and nearly half of them are due to prematurity," the doctor states. "Seventy per cent of the deaths of the premature babies take place in the first twenty-four hours; this is more than double the percentage of deaths of full-term infants during the first day."

He points out that the longer the delivery of a premature infant can be delayed the greater is the weight of the unborn child and the lower the infant mortality.

"Mortality can be reduced if every pregnant woman has her blood pressure determined and her urine, heart, and lungs examined every month during her pregnancy," the doctor states. "The oftener a pregnant woman visits her physician, the greater is the probability of her having a normal living infant. The mother also should visit her dentist two or three times during pregnancy so that her teeth may be kept in good condition."

Proper feeding of the infant and immunization against such diseases as smallpox, whooping cough, diphtheria, typhoid, and paratyphoid fever are some of the other measures named by Doctor Davison for the preservation of child health.

Deficiency diseases, such as pellagra, rickets, and scurvy, can be prevented by proper diets. Deaths from automobile accidents are preventable, especially for children, who should be taught at home and at school to take precautions constantly.

"Benefit from vaccination against infantile paralysis has been proved, but during an epidemic children under twelve years of age should avoid crowds, swimming pools, and indoor contacts with other children and especially adults, many of whom may be carriers.

"Everyone must be instructed not to expectorate or cough while near children or to kiss them. Any member of the family, servant, nurse, and any other person who comes in contact with children should be carefully examined by x-rays for tuberculosis if such a person has a chronic cough, however mild."—*Santa Clara Journal*, April 5.

LETTERS

Subject: Number of Licensed Naturopaths in California.

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF
PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS

San Francisco, California,
March 30, 1940.
Yours of March 25,
Re: Naturopaths.

Dear Doctor Kress:

This will acknowledge receipt of your letter of March 25, which reads:

"Kindly send to me your latest figures concerning the total number of naturopaths who are licensed to practice in the State of California. Mr. J. W. Holloway, Jr., Acting Director of the American Medical Association Bureau of Legal Medicine and Legislation, seeks this information."

In reply, beg to direct your attention to the 1939 directory published by the Board of Medical Examiners, wherein on page 29 appears the notation that there are thirty-one naturopaths in active practice, who were licensed by the special act of the legislature in 1909, which is mentioned

in the last paragraph of page 26 of said directory. Since that time no license to practice naturopathy, *per se*, has been issued under the laws of this state. A large number of licensed chiropractors hold naturopathic diplomas, obtained by one means or another, but are not licensed "to practice naturopathy." This chiropractic group, in conjunction with several other holders of naturopathic diplomas, have at practically every legislative session endeavored to secure passage of a naturopathic bill, but so far without success.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Subject: Use of the title "Doctor."

(COPY)

Sacramento, California,
April 8, 1940.
Yours of March 28,
Re: _____

Dear Doctor:

There is no provision in the law which compels a graduate of an osteopathic school holding a physician's and surgeon's license and who uses the prefix "Dr." to follow his name with the suffix "D. O." or any indication that he is a graduate of an osteopathic school.

The last Legislature passed a law requiring all licentiates, excepting holders of physician's and surgeon's licenses who use the prefix "Dr.," to follow their name with the words "Drugless Practitioner," or "Chiroprapist," as the case might be.

The Chiropractic Initiative requires a licentiate thereunder who uses the prefix "Dr." to follow his name with the suffix "D. C." or the word "Chiropractor."

Regretting our inability to help you in the matter mentioned in your letter, believe me

1020 North Street.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Subject: Trichinelliasis in San Francisco—The Type of Food Involved.

(COPY)

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

April 13, 1940.

To the Editor:—For the eleven-year period, 1929 to 1939 inclusive, there were 264 cases of human trichinelliasis reported to the Department of Public Health in San Francisco. In tracing down the source of the disease, in respect to the alleged food involved, it is interesting to note that the survey shows the following:

Food	Cases
Pork sausage	58
Salami	54
Fresh pork	36
Mettwurst	30
Ground pork and meat loaf	11
Raw pork	8
Pork chops or steaks	5
Ham	4

Other foods noted included imported sausage, head cheese, mixed Chinese food, pickled pork, raw bacon, smoked pork, and thirteen cases in which the food was unknown. Of unusual interest was the reporting of seven cases in which the food causing the trichinelliasis was bear meat.

In 1934, of the thirty cases of trichinelliasis reported, many were traced to salami, and strict control measures were instituted for the preparation and sale of salami.

Active control regulations covering the display of placards warning the public to cook all pork thoroughly, such cards being placed in retail butcher shops and in kitchens of restaurants and hotels, together with the enforcement of higher standards on hog ranches supplying pork to the San Francisco abattoirs, the elimination by condemnation of others, and also a laboratory check on fresh pork entering the San Francisco abattoirs, all contributed in reducing the number of cases reported.

Beginning with 1935, the number of cases of trichinelliasis reported were as follows:

	Cases
1935	31
1936	18
1937	9
1938	19
1939	3

This was in definite contrast to the cases reported for the six years preceding 1935, when there were 184. It could be considered, therefore, that improvement has been made in the attempt to eradicate trichinelliasis in San Francisco.

This survey has demonstrated some of the difficulties involved in obtaining specimens of food for laboratory analysis where trichinelliasis is suspected. Of the 264 cases reported for the period 1929-1939, inclusive, laboratory examination of the food involved was obtained only in twenty. Diagnosis in many cases was by clinical findings and examination of the patient's blood for further confirmation.

101 Grove Street.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

Subject: Address by Paul de Kruijff.

SAN FRANCISCO TUBERCULOSIS ASSOCIATION

April 8, 1940.

To the Editor:—Attached is a brief notice of a dinner to be held in San Francisco on the evening of May 28, at which Paul de Kruijff will be the principal speaker. We will be grateful if you can give such notice of it as you consider appropriate in the next issue of CALIFORNIA AND WESTERN MEDICINE.

Yours truly,

WILLIAM C. VOORSANGER, M. D.,
Secretary.

♦ ♦ ♦

San Francisco Tuberculosis Association.—Paul de Kruijff, bacteriologist and author of various books dramatizing progress in medical science, will be the principal speaker at a dinner in the Hotel St. Francis the evening of Tuesday, May 28, arranged by the San Francisco Tuberculosis Association.

Dr. Sidney J. Shipman, president of the California Tuberculosis Association, was chairman of the committee in charge. Other members of the committee were: Dr. George H. Becker, director of the Bureau of Communicable Diseases, Department of Public Health; Rev. Richard T. Howley, assistant director of Catholic charities and director of Catholic hospitals in San Francisco; Dr. Karl F. Meyer, director of the Hooper Foundation for Medical Research; and Dr. William C. Voorsanger, president of the municipal Board of Health.

Subject: Medical Advice Over the Radio.

To the Editor:—The following resolution has been endorsed by the Medical Society of New Jersey:

Resolved, That the Joint Committee on Professional Relations request the Medical Society of New Jersey and the

New Jersey Pharmaceutical Association to enter a formal protest against the prescribing of medicines and the giving of medical advice on the radio, with the exception of such broadcasts on health matters as are given under the auspices of recognized associations of licensed physicians or federal, state, and local health departments; and be it further

Resolved, That such protest be sent to the broadcasting companies and the Federal Communications Commission.

We stated that promotion of self-medication over the radio on behalf of nostrums was becoming more subtle and that radio announcers endeavored to tie up their messages with complimentary references to the medical and pharmaceutical professions. We further stated that, in our opinion, the time had arrived for action to curtail this sort of activity and we expressed the hope that your organization would pass a resolution similar to the one noted above. . . .

JOINT COMMITTEE ON PROFESSIONAL RELATIONS.

Prescott R. Loveland, Secretary.

Subject: Testimonial Dinner to Dr. George Dock on His Eightieth Birthday.

To the Editor:—On the evening of April 2, 1940, at a dinner at the headquarters of the Los Angeles County Medical Association, Dr. George Dock, surrounded by some seventy of his friends, colleagues, and former students, celebrated his eightieth birthday. Although his real birthday falls on April 1, a happy conjunction of events led to its celebration on April 2. These events were the founding of the George Dock Lectureship by the Walter Jarvis Barlow Society of the History of Medicine, and its initiation by Doctor Dock himself as the first lecturer.

The celebration was, therefore, in the nature of a triple birthday—the birth of the Walter Jarvis Barlow Society of the History of Medicine whose first public meeting it was, the birth of the George Dock Lectureship in the History of Medicine, and the eightieth birthday of Doctor Dock.

After three powerful puffs which disposed of the eighty lighted candles surrounding his birthday cake, Doctor Dock was permitted to sit back and listen to the many messages from all parts of the United States and Canada. There was a message from Charles Perry Fisher of Philadelphia, who for many years was librarian of the College of Physicians and whom Doctor Dock called "the first medical librarian" he had ever seen, reminding him of his first years as a medical student in Philadelphia. There was a message from Dr. Rock Sleyster, President, and Dr. Alphonse McMahon, Vice-President, of the American Medical Association; from Dr. George H. Kress, Secretary of the California Medical Association; from Dr. Roy E. Thomas, President, Dr. Paul Ferrier, Vice-President, and Dr. L. A. Alesen, Secretary, of the Los Angeles County Medical Association; from Dr. Elizabeth Mason Hohl, President-Elect of the American Medical Women's Association; and from Dr. H. E. Schiffbauer, Chairman of the Library Committee of the Los Angeles County Medical Association.

Then, from the various institutions where he had taught, there were warm reminders that he still lives in the memory of those with whom he worked, and that the monuments he built in teaching, organization, and friendship still stand. Thus there was a message from Dr. Alexander Ruthven, President of the University of Michigan; from Dr. C. C. Bass, former dean of the Medical School of Tulane University, New Orleans, who was most closely associated with Doctor Dock while he was in New Orleans; and from many friends on the faculties of these institutions who expressed their happiness at having known Doctor Dock, and their appreciation of the good influence he had on their lives, many dating this influence back as long as forty years. From St. Louis came greetings from colleagues,

friends, students, and librarians, with whom he had been intimately associated during his teaching period there.

From his associates in Los Angeles, several of whom had known him since the days of his occasional visits to Southern California, which began in 1903, and from others who knew him since he came to settle permanently in 1923, there were messages of felicitation and of appreciation of their good fortune in having him here and wishing him, as he had wished himself, "to live as long as Old Parr."

It was recalled by some that as long ago as 1907 when the Barlow Medical Library was dedicated, Doctor Dock, then in Ann Arbor, sent a gift of a rare book to commemorate the occasion. This work, as Mrs. Mary E. Irish, the present librarian of the Los Angeles County Medical Association, which took over the Barlow Medical Library in 1934, pointed out, was the beginning of a constant stream of gifts to the library, which seems to be increasing in volume as the years go by.

Dr. Milbank Johnson, one of Doctor Dock's earliest acquaintances in Southern California, and the first librarian of the Barlow Medical Library, spoke of the valuable spiritual incentive which Doctor Dock has given to the library since its founding.

Mrs. Barlow, happily present, spoke of her pleasure in knowing that Doctor Barlow had a spiritual heir in Doctor Dock, whose interest in the library carries on the tradition which Doctor Barlow wished to have continued. . . .

At the conclusion of the lecture, Dr. Donald A. Charnock, President of the Barlow Society, announced the plan to publish the lecture and other contributions to this triple celebration in a commemorative volume of suitable format. Thus was ended an inspiring evening which can come only infrequently in the life of any man.

HYMAN MILLER, M. D.,
Secretary, Walter Jarvis Barlow Society
of the History of Medicine.

Subject: Japanese and Chinese Births in San Francisco.

OFFICE OF
DIRECTOR OF PUBLIC HEALTH
CITY AND COUNTY OF
SAN FRANCISCO

March 30, 1940.

To the Editor:—I am attaching statistics relative to births of Japanese in San Francisco. I think these figures are most interesting. Also attached is a similar tabulation regarding Chinese births.

With kindest regards,

Sincerely,

J. C. GEIGER, M. D.,
Director.

JAPANESE POPULATION
(U. S. Census)

1910	4,518
1920	5,358
1930	6,250

JAPANESE BIRTHS

1910	116*
1911	106
1912	161
1913	212
1914	231
1915	260
1916	295
1917	262
1918	263
1919	278
1920	327†
1921	318
1922	309
1923	300
1924	270
1925	288
1926	221

1927	181
1928	170
1929	135
1930	126‡
1931	100
1932	93
1933	88
1934	67
1935	74
1936	66
1937	82
1938	77
1939	77

*25.7, rate. †61.0, rate. ‡20.2, rate.

* * *

CHINESE POPULATION
(U. S. Census)

1910	10,582
1920	7,744
1930	16,303

CHINESE BIRTHS

1910	134*
1911	161
1912	174
1913	186
1914	196
1915	194
1916	221
1917	187
1918	189
1919	203
1920	201†
1921	255
1922	347
1923	378
1924	451
1925	414
1926	395
1927	438
1928	397
1929	362
1930	382‡
1931	369
1932	321
1933	302
1934	279
1935	225
1936	226
1937	211
1938	214
1939	222

*12.7, rate. †26.0, rate. ‡23.4, rate.

Subject: Recent Annual Session of the California Tuberculosis Association.

April 20, 1940.

To the Editor:—The 1940 annual meeting of the California Tuberculosis Association has gone into history. Everyone believes that it was one of the best and most successful meetings we have ever had.

A large part of the interest which was shown in this meeting may be attributed to excellent advance publicity, and in this regard we wish to thank CALIFORNIA AND WESTERN MEDICINE for its assistance and coöperation.

45 Second Street, San Francisco.

Sincerely yours,

W. F. HIGBY,
Executive Secretary.

Subject: Conference on School Health Education.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
SACRAMENTO

To the Editor:—Enclosed is a brief statement concerning the Conference on School Health Education to be held in Berkeley this summer. It would assist greatly in informing school physicians and others of the Conference if you could find space for the notice in CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,

W. M. DICKIE, M. D.
Director of Public Health.

CONFERENCE ON SCHOOL HEALTH EDUCATION

Sponsored by California State Department of Education
State Department of Public Health
University of California, Berkeley
July 22-25, Inc., 1940

A Conference on School Health Education, sponsored by the State Departments of Education and Public Health, will be conducted during the summer session on the University of California campus in Berkeley by Dr. Mayhew Derryberry, Chief of Health Education Studies, National Institute of Health, United States Public Health Service.

Dates of the Conference are July 22 to 25, inclusive. The program is planned to be of value to educators and to workers in public health. Lectures will be interspersed with showings of new motion pictures, exhibits of educational materials and field trips to clinics, child-health conferences, public-health laboratories, and other places of interest.

Doctor Derryberry will conduct discussions on problems which arise in introducing units of health instruction in other courses, on values and limitations of special hygiene courses and on the evaluation of school health education.

Lectures by other experts in the fields of education and public health will deal with school health education services and materials available in California from federal and local sources, the control of communicable diseases, and problems of nutrition.

For further information and registration, write Conference on School Health Education, Haviland Hall, University of California, Berkeley, California.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Unfortunate Results of Eye Operation Not a Ground of Liability

A recent California case, *Adams vs. Boyce, et al.*, 100 Cal. App. Dec. 794, is one case which should be of interest to the profession at large, because of the manner in which certain well-established rules of law relating to malpractice cases were applied.

On the morning of November 27, 1935, plaintiff, while using a carpenter's wrecking bar, suddenly felt something strike his right eye. Upon looking into a mirror and observing a small red spot in the extreme right corner of the eye, plaintiff went to Santa Monica where he had three x-ray films taken of his eye. The same afternoon he consulted one of the defendant doctors who examined the eye and attempted to secure the use of a giant magnet from a hospital. He was unsuccessful because he was not a member of the hospital staff. The following day, plaintiff attempted to obtain treatment at the General Hospital of Los Angeles. At that institution another x-ray was taken by another defendant doctor. While at the hospital, plaintiff met a third doctor (also a defendant), with whom he talked concerning the injury. Plaintiff was refused treatment at the hospital and on November 29 went to the California Hospital and was admitted as a patient. At one o'clock and again at three o'clock of that afternoon, plaintiff telephoned to the doctor he had met at the county hospital (Doctor B) and at the latter time, after informing the doctor that no x-rays had as yet been taken, plaintiff was told to put on his clothes and come down to the doctor's office. From that point he was taken to the office of another defendant doctor in the same building, at which place x-rays were taken. Later in the same day plaintiff returned to the hospital and at five o'clock was taken into the operating room.

Concerning the operation, plaintiff testified as follows:

Upon arrival at the operating room, one Dr. R., still another defendant, washed around the area of his eye and

covered his left eye with a bandage. Dr. B. then stuck something into plaintiff's upper and lower lids and proceeded to hold a pair of scissors up above his eye. Plaintiff felt a twisting motion on his side and all of a sudden there was a give and it seemed like he pushed something into the eye. Plaintiff said that all during this time his eye was looking straight up. Dr. B. then asked the nurse for the magnet, and plaintiff heard a humming sound. Pretty soon Dr. B. said, "I can't find it and it isn't magnetic." Plaintiff testified that he stated to Drs. B. and R. that the steel chip hit the eye way over on one side and that the first redness appeared over on the side and that x-rays disclosed it to be lodged over on the side. Dr. B. asked the nurse for something and he squeezed it into plaintiff's eye, wiped it out and put a patch on.

Dr. B. described the operation in substance as follows: After the eye was anesthetized, the conjunctiva was picked up approximately over the foreign body and was dissected back over the foreign body, exposing the sclera. Then a little opening was made in the wall of the eye with a cataract knife, just a tiny, little opening, and then the magnet was put up against this opening and the current turned on. That was done at least a dozen times and no foreign body came. Dr. B. testified: "After I saw that the magnet was not going to pull the foreign body, I took a tiny, little pair of iris scissors and introduced the tip end of the scissors about four millimeters. I did that in preference to putting the tip of the magnet, because the magnet is a great big thing and would have enlarged the wound. I put the scissors into the little opening almost in contact with the foreign body and then touched them with the magnet."

On the morning of December 2, Dr. B. took plaintiff to the office of another defendant, Dr. I., where the two doctors looked into plaintiff's eye with an ophthalmoscope and saw the foreign body still within the eye. On the following Thursday plaintiff's eye was swollen shut, whereupon he went to Dr. B., who looked into the eye without an instrument and, according to plaintiff, said, "My God! Something's happened! You have panophthalmitis," and suggested that plaintiff go to a local hospital for injection of foreign protein and then keep hot applications on his eye, two hours on and one off, for ten days. Plaintiff testified that Dr. B. stated he could do no more for plaintiff and that the latter should go to Santa Monica and get taken care of locally. Plaintiff subsequently lost the use of the eye.

From the facts above stated, the Court held that of all the various defendants none could be held liable. A nonsuit was granted in favor of Dr. J., one of the roentgenologists, because there was no evidence at all of any negligence on his part. The Court held that there was also no evidence of any negligence on the part of the other roentgenologists. In regard to Drs. B. and R. and the defendant hospital, the Court stated:

Assuming that the record presented a case of mistaken diagnosis, it is totally lacking in any incidents of carelessness or unskillfulness necessary to constitute actionable negligence. When due care, diligence, judgment, and skill are exercised, a mere failure to diagnose correctly does not render a physician liable."

The Court further stated that in the present case it was impressed with the fact that plaintiff had not even proved a mistaken diagnosis.

The Court reiterated the well-settled rule of *Hesler vs. California Hospital Co.*, 178 Cal. 764, where it was said that the law requires of the physician only

First, that he shall have the degree of learning and skill ordinarily possessed by physicians of good standing practicing in that locality, and, second, that he shall exercise reasonable and ordinary care and diligence in treating the patient and in applying such learning and skill to the case. The law takes cognizance of human weakness and liability to err in the application of skill and learning, and it requires only the exercise of reasonable and ordinary care and diligence to avoid error.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 5, May, 1915

From Some Editorial Notes:

Exposition-Year Vacation and the American Medical Association.—If you have not already done so, begin now to plan your vacation. Everyone who works hard, particularly along the line of brain work with its attached responsibilities, should take a complete rest from such occupation for at least a few weeks at some time during the year. You owe that rest to yourself and your patients. This year you can so arrange your vacation as to make it not only a rest, but a wonderful and instructive outing as well; plan your trip so as to spend some part of the time in San Francisco during the third week in June. The scientific work in the sections of the American Medical Association will be very good; the exhibits in connection with public health activities will be very fine and very illuminating. And then there is the wonderful Exposition, with thousands of things you will want to see and to know about. You can hardly afford not to see the Exposition, and you might as well come at a time when you will get the most out of your trip—the week beginning June 21, 1915. Do not forget it and begin to plan now to be here at that time.

Defense by Insurance Companies.—Recently some new points in regard to the defense of suits for damages for alleged malpractice, and the attitude of insurance companies thereto, have been brought to our attention. . . . If you are insured in a casualty company, read your policy carefully; probably not one physician in a thousand, having insurance, has ever read his policy through enough times to know its provisions. . . . The company agrees to do certain things, provided (and that is vitally essential) the physician does certain things, only one of which is paying the premium. If the insured does not live up to his part of the contract, that releases the company from its portion of the contract, and the physician might as well have no insurance. He has simply thrown his good money away. That is why the Council instructed the Secretary to be very explicit in warning a member who is threatened or sued to notify the insurance company immediately, in case such member carries insurance. . . .

Legal Absurdity.—A curious case has come up in the southland. A member who holds insurance in an indemnity company has been sued, not for alleged malpractice, but for breach of contract, and the insurance company states that it does not insure against breach of contract, but only against claims of malpractice, carelessness or errors of judgment. . . . In all probability this case will fall to the ground; but it serves well to bring up a new point—be very careful in your statements to the patient before an operation, and never undertake or contract to do a certain limited and specified thing. Furthermore, it would be very wise, in all serious operative conditions, to have the whole statement of the case, and what is to be done by the surgeon regardless of limitation, specified in writing. . . . We are protecting ourselves, and each other, for carelessness leading to a judgment against a physician invariably stirs up other people to sue other physicians.

Investigate All Applicants.—Again must we urge all county society secretaries to send in the names of applicants. (Continued in Front Advertising Section, Page 28)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Members of county hospital staff 'are liable for their own negligence in treating patients and the county is not jointly liable with them,' county counsel ruled today in notifying Dr. B. A. Adams, hospital superintendent, that the county is not permitted under law to insure the resident physicians and others of the medical staff, including internes and nurses. . . . In each possible instance of alleged malpractice, the individual employee responsible must assume sole liability, the opinion advised. . . ." (San Diego *Sun-Tribune*, March 19, 1940.)

"The Connecticut supreme court of errors, upholding the constitutionality of the State's birth control law, ruled today that it was illegal for a physician to prescribe contraceptives to a married woman even if he believed that her 'general health' would be affected by pregnancy. The lower court had held that the law, which makes the practice of birth control by anyone a criminal offense, was unconstitutional if it were construed as lacking an exception 'protecting the right of any physician to prescribe drugs, medical articles or instruments for the purpose of preventing conception.' The supreme court, however, pointed out that the legislature had repeatedly refused to make such an exception and added that 'courts may not by construction supply omission in a statute, or add exceptions merely because it appears to them that good reasons exist for adding them.' The case was brought to the supreme court after two Waterbury physicians and a nurse, arrested under the Birth Control Act, had challenged its constitutionality on the ground that persons had a natural right to 'decide whether or not they shall have children.' That natural right, the court held, was 'subject to the limitation' that a person may not exercise it 'so as to injure his fellow citizen or endanger the vital interest of society.'" (Associated Press Dispatch, dated Hartford, Connecticut, March 20, printed San Francisco *Examiner*, March 21, 1940.)

On March 18, 1940, Congressman John H. Tolan, Seventh District of California (Albany, Berkeley, Emeryville, Piedmont and Oakland), introduced in the House of Representatives House Resolution No. 8963 to amend Section 40 of the United States Employees Compensation Act, as follows:

"The term 'physician' includes surgeons and osteopathic and chiropractic practitioners within the scope of their practice, as defined by state law. The term 'medical, surgical, and hospital services and supplies' includes services and supplies by osteopathic and chiropractic practitioners and hospitals within the scope of their practice as defined by state law."

The bill has been referred to the Committee on Judiciary.

"Rich Dr. St. Louis Estes, according to his own not inconsiderable claims, was an invalid for 48 years, blind for two and baldheaded for 18. Through his back-to-nature living with a raw food diet and sunshine, still according to his claims, he has cured all these disabilities and at 72 is strong and healthy. Furthermore he has computed his life expectancy to be 162 years. . . . Although Doctor Estes' formula has assertedly been successful with his own family, (Continued in Back Advertising Section, Page 39)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

